

EXHIBIT C

PROOF OF POLICY CLAIM FORM

PROOF OF POLICY CLAIM FORM

Date: [_____]

Ambac Assurance Corporation,
as Management Services Provider of
the Segregated Account of Ambac Assurance Corporation
One State Street Plaza
New York, NY 10004
Attention: Claims Processing
Email: claimsprocessing@ambac.com
Facsimile: (212) 208-3404

Reference Policy Number: [_____]

Reference is made to (i) the Plan of Rehabilitation of the Segregated Account of Ambac Assurance Corporation, Case No. 10 CV 1576, dated October 8, 2010 (the "Plan of Rehabilitation"), (ii) the attached claim schedule, which includes detailed information about the claim made pursuant to this Proof of Policy Claim Form (the "Claim Schedule") and (iii) the Policy issued by Ambac Assurance Corporation ("Ambac"), identified above and on the Claim Schedule (the "Policy"), with respect to the insured obligation identified on the Claim Schedule (the "Insured Obligation"). Terms capitalized herein and not otherwise defined shall have the meanings ascribed to such terms in or pursuant to the Plan of Rehabilitation or the Policy, as the case may be, unless the context otherwise requires.

The undersigned hereby certifies as follows:

1. The undersigned is a Holder under the Policy and is entitled, pursuant to the provisions of the Policy, to submit a claim for the "Total Claim Amount" set forth on the Claim Schedule with respect to the Insured Obligation (the "Total Claim Amount").
2. The information set forth on the Claim Schedule is true, correct and complete.
3. The "Total Claim Amount" set forth on the Claim Schedule with respect to the Insured Obligation (the "Total Claim Amount") is due for payment pursuant to the terms of the Policy and the contracts and instruments relating to or governing the Insured Obligation.
4. The undersigned has not previously made a claim or demand for payment under the Policy in respect of amounts due on the Insured Obligation on the "Distribution Date" indicated on the Claim Schedule, except as otherwise specified in an addendum to this Proof of Policy Claim Form submitted by the Holder herewith.

5. [Select one of the following:] [The undersigned submitted a payment schedule in the form attached to this Proof of Policy Claim Form when it made a prior claim under a Proof of Policy Claim Form with respect to the Policy, and the information set forth on such payment schedule continues to be true, correct and complete.] **OR** [It is submitting a payment schedule in the form attached to this Proof of Policy Claim Form, and the information set forth on the attached payment schedule is true, correct and complete. The undersigned is submitting the attached payment schedule because [select one of the following:] [this is the first claim submitted under a Proof of Policy Claim Form with respect to the Policy] **OR** [the information set forth on a previously submitted payment schedule is no longer true, correct or complete].]

6. [If the Policy requires the Holder to submit a claim or demand for payment in a specified form, include the following:] [The undersigned has duly completed and submitted a claim or demand for payment in the form specified by the Policy, a copy of which is attached hereto, and the amount claimed therein is equal to the Total Claim Amount.]

Without prejudice to (i) the terms and provisions of the Policy and any other related underlying instrument(s) or contract(s) and (ii) any assignment previously executed, whether pursuant to a Proof of Policy Claim Form or otherwise, the undersigned [include the following, if applicable:] [, in its capacity as trustee and on behalf of the beneficial owners of the Insured Obligation], hereby assigns to Ambac all of its rights, title and interests [include the following, if applicable:] [, including rights, title and interests held by it on behalf of the beneficial owners of the Insured Obligation,] with respect to the Insured Obligation, to the extent of any payments by the Segregated Account with respect to such Insured Obligation; the foregoing assignment is in addition to, and not in limitation of, rights of subrogation otherwise available to Ambac or the Segregated Account in respect of such payments. The undersigned shall take such action and deliver such instruments as may be reasonably requested or required by Ambac or the Segregated Account to effectuate the purpose or provisions of the foregoing assignment.

The undersigned hereby acknowledges that the issuance of Surplus Notes by the Segregated Account in lieu of any Cash payments required to be made to the undersigned or any beneficial owner on whose behalf the undersigned is presenting this Proof of Policy Claim Form constitutes full and complete satisfaction of such payment obligation of the Segregated Account in respect of such claim, regardless of the existence of any provision in the Policy or any other underlying instrument or contract that would require, or that contemplates, the discharge of the obligations of the Segregated Account through the payment of Cash or otherwise.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE SEGREGATED ACCOUNT, THE REHABILITATOR OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTY.

[_____],
as Holder

By: _____
Name:
Title:

PAYMENT SCHEDULE

Payments in Cash

(a) The undersigned hereby requests, as contemplated in Section 4.04(c) of the Plan of Rehabilitation, that the portion of the Total Claim Amount to be paid by the Segregated Account in Cash be made to the following account by bank wire transfer of federal or other immediately available funds:

Bank Name: [_____]
ABA #: [_____]
Acct #: [_____]
Reference: [_____]

(b) [Complete the following if the Holder is a Trustee:] The undersigned hereby agrees that, following receipt of any cash payment by the Segregated Account, it shall (i) cause such funds to be distributed in accordance with the provisions of the underlying instrument or contract relating to the Insured Obligation, and (ii) maintain an accurate record of such payments with respect to the Insured Obligation and the corresponding claim on the Policy and proceeds thereof.

Payments in Surplus Notes

(a) The undersigned hereby requests (mark one):

1. a beneficial interest in a global Surplus Note [*include the following, if applicable:*] [, in its capacity as trustee on behalf and for the benefit of the beneficial owners of the Insured Obligation], in the aggregate amount of that the portion of the Total Claim Amount to be paid by the Segregated Account in Surplus Notes to be delivered as follows:

Name:
DTC Participant Name:
DTC Participant #:
A/C # (if applicable):
A/C Name:
Agent's Contact Information:

2. that a beneficial interest in a global Surplus Note, in the aggregate amount of that the portion of the Total Claim Amount to be paid by the Segregated Account in Surplus Notes, be delivered to the Segregated Account, and that such interests be subsequently transferred by the Segregated Account to the beneficial owners of the Insured Obligation or their custodians; provided, that prior to

electing this option, the undersigned shall have (i) executed and submitted a letter to The Depository Trust Corporation (“DTC”) advising it that the Segregated Account is an approved third party relating to the CUSIP or CUSIPs to which this Proof of Policy Claim Form relates, which authorization shall permit the Segregated Account to request Security Position Reports directly from DTC relating to such CUSIP or CUSIPs, and (ii) entered into documentation reasonably satisfactory to the Segregated Account.

3. a certificated Surplus Note in the name of [_____]
[include the following, if applicable:] [, in its capacity as trustee on behalf and for the benefit of the beneficial owners of the Insured Obligation,] in lieu of a beneficial interest in a global Surplus Note.¹

[_____],
as Holder

By: _____
Name:
Title:

¹ This election is subject to the approval of the Management Services Provider, in accordance with Section 4.04(d) of the Plan of Rehabilitation.

	CLAIM SCHEDULE			
Trustee (if applicable):				
Insured Obligation (name of bond/other):				
Policy #:				
Distribution Date:*				
Claim Period:**				
Total Claim Amount:				
CUSIP	Short Name	Principal Claim Amount	Interest Claim Amount	Total Claim Amount
Total				
*Distribution Date is the date on which principal and/or interest is due for payment with respect to the Insured Obligation.				
**Claim Period is the period for which payments are due on the Distribution Date.				
Please use a different Proof of Policy Claim Form and Claim Schedule for each Distribution Date.				