EXHIBIT C

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, as approved by the Circuit Court of Dane County, Wisconsin on January 24, 2011 (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. 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: [_____]

6. [*Complete the following if the Holder is a trustee and/or agent for the beneficial holder of the Insured Obligation:*] The undersigned hereby agrees that, following receipt of any cash payment by the Segregated Account in respect of the Total Claim Amount, 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.

7. The undersigned has submitted to Ambac a Surplus Note Payment Schedule with respect to the Policy in the form attached to the Guidelines Under Plan of Rehabilitation (Claims Processing for Policy Claims) dated as of February 18, 2011 as Exhibit A, and the information set forth in such Surplus Note Payment Schedule continues to be true, correct and complete.

8. [*If the Policy requires the Holder to submit a claim or demand for payment in a specified form or to have satisfied certain conditions, include the following:*] [The undersigned has duly completed and submitted to Ambac a claim or demand for payment in the form specified by the Policy, a copy of which is attached hereto, and all other conditions to the receipt of the Total Claim Amount have been satisfied, 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:

	CLAIM SCHEDULE				
Party submitting Claim:					
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**	**Record Date (Cash and Surplus Notes):*****
Total					

*Distribution Date is the date on which principal and/or interest is due for payment with respect to the Insured Obligation. Please use a different Proof of Policy Claim Form and Claim Schedule for each Distribution Date.

**Claim Period is the period for which payments are due on the Distribution Date.

*** Complete only if option 2 under "Payments in Surplus Notes" is selected on the Surplus Note Payment Schedule relating to this Claim. The record date will be used for distributions of cash and Surplus Notes to beneficial owners of the Insured Obligation. To complete this field, insert either (A) "most recent record date" if the distributions of cash and Surplus Notes are to be made to the holders of record of the Insured Obligation at the time such distributions are made or (B) a specific historical date if the distributions are to be made to holders of record as of a prior date. The same record date should be used for distributions of cash and Surplus Notes relating to a given CUSIP for a given Claim Period.