Fill in this information to identify the case:

Debtor Ample, Inc.

United States Bankruptcy Court for the: Southern District of Texas (State)

Case number 25-90817

Modified Official Form 410

Proof of Claim

04/25

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies or any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. **Who is the current creditor?**

Azriel Samson

Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor

2. **Has this claim been acquired from someone else?**

☑ No

☐ Yes. From whom?

3. **Where should notices and payments to the creditor be sent?**

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	**Where should payments to the creditor be sent?** (if different)
Azriel Samson 1678 Merian Dr Pleasant Hill, CA 94523	
Contact phone 5165320840	Contact phone
Contact email azriel.samson@gmail.com	Contact email

Uniform claim identifier (if you use one):

4. **Does this claim amend one already filed?**

☑ No

☐ Yes. Claim number on court claims registry (if known) Filed on MM / DD / YYYY

5. **Do you know if anyone else has filed a proof of claim for this claim?**

☑ No

☐ Yes. Who made the earlier filing?

25908172601120523580001l0

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. **Do you have any number you use to identify the debtor?**

☑ No

☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ___ ___ ___ ___

7. **How much is the claim?** $ undetermined . **Does this amount include interest or other charges?**

☑ No

☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. **What is the basis of the claim?**

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

failure to provide termination notice in violation of Cal Lab code 1400

9. **Is all or part of the claim secured?**

☑ No

☐ Yes. The claim is secured by a lien on property.

Nature or property:

☐ Real estate: If the claim is secured by the debtor's principle residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.

☐ Motor vehicle

☐ Other. Describe: _____

Basis for perfection: _____

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $_____

Amount of the claim that is secured: $_____

Amount of the claim that is unsecured: $_____ (The sum of the secured and unsecured amount should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $_____

Annual Interest Rate (when case was filed)_____%

☐ Fixed

☐ Variable

10. **Is this claim based on a lease?**

☑ No

☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $_____

11. **Is this claim subject to a right of setoff?**

☑ No

☐ Yes. Identify the property: _____

25908172601120523580001 10

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?**

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

☐ No

☑ Yes. *Check all that apply:*

	Amount entitled to priority
☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$
☐ Up to $3,800* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$
☑ Wages, salaries, or commissions (up to $17,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$ to be determined
☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$
☑ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$ to be determined
☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$

* Amounts are subject to adjustment on 4/01/28 and every 3 years after that for cases begun on or after the date of adjustment.

13. **Is all or part of the claim entitled to administrative priority pursuant to 11 U.S.C. § 503(b)(9)?**

☑ No

☐ Yes. Indicate the amount of your claim arising from the value of any goods received by the debtor within 20 days before the date of commencement of the above case, in which the goods have been sold to the Debtor in the ordinary course of such Debtor's business. Attach documentation supporting such claim.

$_____

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(3) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☐ I am the creditor.

☐ I am the creditor's attorney or authorized agent.

☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.

☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgement that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 03/09/2026
MM / DD / YYYY

/s/Azriel Samson
Signature

Print the name of the person who is completing and signing this claim:

Name: Azriel Samson
First name | Middle name | Last name

Title: _____

Company: _____
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: _____

Contact phone _____ Email _____



Verita (KCC) ePOC Electronic Claim Filing Summary

For phone assistance: Domestic (866) 475-7847 | International (781) 575-2036

Debtor:
25-90817 - Ample, Inc.
District:
Southern District of Texas, Houston Division

Creditor:
Azriel Samson
1678 Merian Dr
Pleasant Hill, CA, 94523
Phone:
5165320840
Phone 2:
Fax:
Email:
azriel.samson@gmail.com

Has Supporting Documentation:
Yes, supporting documentation successfully uploaded
Related Document Statement:

Has Related Claim:
No
Related Claim Filed By:

Filing Party:

Other Names Used with Debtor:

Amends Claim:
No
Acquired Claim:
No

Basis of Claim:
failure to provide termination notice in violation of Cal Lab code 1400

Last 4 Digits:
No

Uniform Claim Identifier:

Total Amount of Claim:
undetermined

Includes Interest or Charges:
No

Has Priority Claim:
Yes

Priority Under:
11 U.S.C. §507(a)(4): to be determined
11 U.S.C. §507(a)(5): to be determined

Has Secured Claim:
No

Amount of 503(b)(9):
No

Based on Lease:
No

Subject to Right of Setoff:
No

Nature of Secured Amount:
Value of Property:
Annual Interest Rate:
Arrearage Amount:
Basis for Perfection:
Amount Unsecured:

Submitted By:
Azriel Samson on 08-Mar-2026 10:28:25 p.m. Pacific Time
Title:
Company:

VN: D35A807CD0F27E0D54B780C1917446B3

9/10/2025

Dear Azriel Samson,

This letter is being sent to you because you are no longer an employee of your worksite employer, Ample Inc, effective 9/10/2025. As a result of your separation from employment with Ample Inc, your status with Sequoia One PEO, LLC ("Sequoia One") is also terminated effective 9/10/2025 .

Termination of Healthcare & Fringe Benefits: If you are enrolled in medical, dental and/or vision benefits at the time of termination, your coverage will terminate on the last day of the month of your termination and you will be eligible to continue benefits coverage through COBRA. Please note, if you participate in the commuter benefit program or in the Flexible Spending Account (FSA), your debit card will be turned off as of the termination date. For commuter benefit participants, any remaining balance in your commuter account is forfeited after your last day of work. For FSA participants, any remaining balance in your account is forfeited after your last day of work, however, you may submit claims until the end of the benefit plan year grace period for expenses incurred through the termination date.

Email Delivery of Benefit Plan Documents and Notices: Sequoia One will provide various benefit plan notices, disclosures, and plan documents (related to applicable Sequoia One health and welfare or retirement plan benefits) to you via your personal email address. Your worksite employer will provide your personal email address to Sequoia One for this purpose. If you would prefer to receive paper copies of any of these documents, would like to opt out of receiving documents electronically, or would like to update your personal email address on file, please reach out to a Sequoia One Advocate at enrollment@help.sequoia.com. If you do not opt-out, you will be deemed to have consented to receiving benefit plan documents and notices from Sequoia One electronically to your personal email address on file.

Benefit plan documents and notices that may be provided to you via email may include, but are not limited to, Summaries of Benefits and Coverage (SBC), Uniform Glossary, HIPAA Notice of Special Enrollment Rights, HIPAA Notice of Privacy Practices, Women's Health and Cancer Rights Act, Newborn's and Mothers' Health Protection Act of 1996, Children's Health Insurance Program (CHIP) Notice, Medicare Part D Notice, Plan Documents and Summary Plan Descriptions (SPD), summaries of material modification, Evidence of Coverage (EOC), and the Summary Annual Report (SAR). Please provide plan documents and notices to any of your dependents covered under the plan.

Access to the WorkLife Portal: You will continue to have access to your account in the Sequoia One WorkLife Portal (where you can retrieve information such as check stubs or W-2s). You can access the WorkLife Portal via this link: www.sequoia.com/worklife and log in using your current credentials.

W-2: You will receive a W-2 Wage and Tax Statement from Sequoia One at the end of the year for the timeframe covered with Sequoia One. If your contact information has changed, please ensure it is updated through the Sequoia One Worklife Portal. If you have elected a paperless W-2 Wage and Tax Statement, this is where you may access the form.

If you have any questions regarding any aspect of your employment with Ample Inc, please contact Ample Inc.

Thank you,

Sequoia One PEO, LLC

Notice to Employee as to Change in Relationship

(Issued Pursuant to Provisions of Section 1089 of the California Unemployment Insurance Code)

Azriel Samson
Name

XXX-XX-1939
SSN

Your employment status has changed for the reason checked below.

☐ Voluntary quit effective _____
Date

☒ Layoff effective 9/10/2025
Date

☐ Discharge effective _____
Date

☐ Job Abandonment _____
Date

☐ Failure to Return from Leave of Absence _____
Date

☐ Other. Employment status changed/will change effective _____ as follows:
Date

_____

_____

_____

Ample Inc
Company

Kim Rosenberg
Company Representative

9/10/2025
Date

Notice to Terminating Employees
Health Insurance Premium Payment (HIPP) Program

The California Department of Health Care Services administers the HIPP program, which is an optional premium reimbursement program under Medi-Cal. If you have recently lost your job and qualify for Medi-Cal benefits, or you are the parent or guardian of someone who qualifies for Medi-Cal benefits, you may be eligible to receive payment for your existing private insurance premium and cost-sharing. In order to qualify for the HIPP program, you must meet all of the following conditions:

1. You must have full scope Medi-Cal coverage;
2. You must have an existing private insurance policy (also referred to as "other health coverage"), a Consolidated Omnibus Budget Reconciliation Act (COBRA) or CAL-COBRA continuation policy, or a COBRA Conversion policy at the time of application for Medi-Cal benefits;
3. You must have a medical condition covered under your existing other health coverage, and you must have received treatment for the medical condition within 90 days of application to the HIPP program;
4. Your other health coverage must be cost-effective to Medi-Cal. This means that the sum of your premium and cost-sharing obligations must be less expensive than the cost that Medi-Cal would pay for your care;
5. You have applied for Medicare benefits.

In addition, you **do not** qualify to participate in the HIPP program if **any** of the following apply:

1. You are not enrolled in Medi-Cal.
2. You do not have full scope Medi-Cal coverage.
3. You are enrolled in Medicare.
4. You are enrolled in a Medi-Cal managed care plan.
5. A court has ordered a non-custodial parent to provide medical insurance to you or your child (if your child is the HIPP applicant).
6. You, or a policyholder under which you are insured as a dependent, is fully reimbursed for your premiums and/or cost-sharing obligations by a third party.

7. Your other health coverage is not cost-effective to Medi-Cal.

8. You do not meet all of the eligibility requirements of the HIPP program.

If you meet all the conditions listed above, you may apply online at http://dhcs.ca.gov/hipp.

If you have questions about how to apply for Medi-Cal benefits, you may contact your local Medi-Cal county office directly at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

If you have questions about Medi-Cal managed care plans, you may contact the Medi-Cal Managed Care Ombudsman at (888) 452-8609 or by email at MMCDOmbudsmanOFFICE@dhcs.ca.gov.

For Persons Who Have an Human Immunodeficiency Virus (HIV)/ Acquired Immunodeficiency Syndrome (AIDS) Disability

The Department of Public Health administers the Office of AIDS HIPP (OA-HIPP) Program. The OA-HIPP program pays monthly health insurance premiums for eligible California residents with a HIV/AIDS diagnosis. This program is available to individuals with health insurance who are at risk of losing it, as well as to individuals currently without health insurance who would like to purchase it. For information, please call (844) 421-7050.