

CLAIM AFFIRMATION FORM

The undersigned claimant certifies, under penalty of perjury, the claimant has read the claim and knows the contents thereof and the claimant is the owner of the said claim and the person entitled to receive the money set forth in said claim.

The claimant agrees to indemnify and hold harmless the State, the Courts and its agents, officers, and employees from any loss resulting from the payment of said claims.

CURRENT INFORMATION AND SIGNATURE MUST BE PROVIDED FOR EACH CLAIMANT OR YOUR CLAIM WILL NOT BE PROCESSED.

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Claimant's Information:

LAST NAME OR BUSINESS	FIRST NAME	MIDDLE INITIAL	SSN OR FEDERAL TAX ID		DATE
CURRENT MAILING ADDRESS			CITY	STATE/PROVINCE	ZIP
					COUNTRY
DAYTIME PHONE	CLAIMANT OR AUTHORIZED AGENT SIGNATURE				

YOUR SIGNATURE MUST BE NOTARIZED IF THE CLAIM AMOUNT IS \$1,000 OR GREATER

For claims filed for a business, the authorized owner's signature is required. For claims filed for an estate or trust the signature of the executor, administrator or attorney is required.

State of California
County of Stanislaus

Subscribed and sworn to (or affirmed) before me on this ____ day of _____, 20____, by _____, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature_____ (seal)

PRIVACY NOTIFICATION

Your Social Security number and other documents are requested for identification and processing of your claim.

CLAIM FOR REIMBURSEMENT

MAIL TO: Superior Court of California, County of Stanislaus
Fiscal Services – Escheatment Personnel
PO BOX 732
Modesto, CA 95353

TODAY'S DATE _____

OWNER'S NAME: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

REIMBURSEMENT CLAIM: \$ _____

NAME OF THE PERSON FILLING OUT THIS FORM AND YOUR RELATIONSHIP TO THE OWNER:

HOLDER'S USE ONLY

Warrants were paid to the holder shown below:

Superior Court of California, County of Stanislaus

Fiscal Services – Escheatment Personnel

PO BOX 732

Modesto, CA 95353

Tax Identification Number: _____

Reason for claimed reimbursement:

**A SEPARATE FORM IS REQUIRED FOR EACH ACCOUNT FOR WHICH
REIMBURSEMENT IS CLAIMED.**

AFFIRMATION AND SIGNATURE *(by court employee)*

I hereby affirm, under penalty of perjury, that I am an authorized agent of the holder named in this Claim for Reimbursement and duly authorized to make said claim upon the Superior Court of California, County of Stanislaus. The above-named holder hereby agrees to indemnify and hold harmless the State, the Courts, its officers and employees from any loss as a result of payment of the amount claimed.

Signature: _____

Date: _____