NOTICE OF CLAIM

NORTH DAKOTA INSURANCE DEPARTMENT
STATE BONDING FUND
SFN 12199 (8-2011)

For Bonding Fund Office Use Only.

Bond Number	Claim Number

NDCC 26.1-21

Name of Obligee (Insured)			Amount of Claim
Name of Contact Person	Title		Telephone Number
Name of Bonded Employee and/or Official			Social Security Number *
Address	City	State	ZIP Code
Title	Date Bonded		Amount of Bond
Default Discovered By	Title		Date Discovered

Details of Default and Circumstances Leading to Discovery:

CLAIM MUST BE FILED WITHIN 60 DAYS OF DISCOVERY OF DEFAULT OR THE CLAIM WILL BE WAIVED.

STATE OF NORTH DAKOTA)
)ss
COUNTY OF _____)

Subscribed and sworn to before me on

_____

_____
Notary Public

My commission expires: _____

(Seal)

Claim is hereby filed against the North Dakota State Bonding Fund:

Signature of Obligee
Title
Date

RETURN TO:

North Dakota Insurance Department
600 E. Boulevard Ave.
Bismarck, ND 58505-0320
Telephone: 701-328-9600
FAX: 701-328-9610

RECEIVED: NORTH DAKOTA STATE BONDING FUND

Received By
Date Received

* In compliance with the Federal Privacy Act of 1974, the disclosure of the Social Security number on this form is mandatory. Numbers are not disclosed to the public and are used to identify the employee and/or official. While disclosure is requested, failure to do so will not invalidate this application but may cause a delay in processing.