**UNSATISFIED CLAIM AND JUDGMENT FUND**
**RECOVERY CERTIFICATION**

Injured Party:
Date of Loss:
Carrier:
Carrier Claim Number:
EMB File Number:
Amount Requested: $

I,____________, am the ______________ of ______________ seeking reimbursement
(Name of Affiant) (Title) (Name of Insurer)
for Personal Injury Protection excess medical benefits paid by the Insurer on behalf of the above listed injured party. I hereby certify that I am authorized to file this certification on behalf of the insurer.

I further certify that this Insurer has not received, from any source, reimbursement, contribution, or indemnification of the PIP excess medical benefits paid by the Insurer on behalf of the above listed injured party and for which reimbursement is sought from the UCJF.

I further certify that this Insurer has either (i) prosecuted or is prosecuting an action, including by agreement or arbitration in matters subject to N.J.S.A. 39:6A-9.1, against all potentially responsible tortfeasors, or (ii) examined the documents and considered the factors set forth at N.J.A.C. 11:3-28.13(c), and determined not to prosecute an action.

I further certify that the foregoing statements are true and correct to the best of my information, knowledge and belief, and that the UCJF may rely on this Certification in determining to provide reimbursement of PIP excess medical expense benefit payments. I am also aware that if any of the foregoing statements made by me are false, the UCJF shall be entitled to discontinue reimbursements on this claim and recover any reimbursements already made to the insurer on this claim pursuant to N.J.A.C. 11:3-28.13(a)2.

___________________ ______________________________________
Date Signature

______________________________________
Name and Title (print)

______________________________________
Telephone Number

______________________________________
E-Mail Address