



New Jersey Property-Liability Insurance Guaranty Association

As Statutory Administrator of the Unsatisfied Claim and Judgment Fund ("UCJF")

233 Mount Airy Road
Basking Ridge, NJ 07920
Tel: (908) 382-7100; Fax: (908) 382-7150

Claim Number: _____

AFFIDAVIT IN SUPPORT OF UCJF ELIGIBILITY

I, the applicant, understand that all sections of this Affidavit must be completed in full by me and signed by me. I will answer "None" or "Not Applicable" where appropriate and will not leave any questions that request information blank. If any question cannot be fully answered in the space provided I will attach additional sheets of paper and provide all information that has been requested. I understand that all requested documents must be submitted with or attached to this Affidavit. **I understand that if I knowingly file a statement of claim containing any false, inaccurate or misleading information, or intentionally omit information material to the claim, doing so will result in the denial of benefits and may subject me to criminal and/or civil penalties.**

1. Claimant Name: _____ Date of Birth: ____/____/____ Gender: M F
(Month, Day, Year)

2. I have also used the following names: _____
Attach another blank sheet if needed to list all names including aliases, nicknames, maiden names, and any other name variations

3. Date of accident: ____/____/____
(Month, Day, Year)

4. Accident location: _____, _____, _____
(Street Address / Intersection) (City) (State)

5. On the date of the accident, I lived at: _____, _____, _____
(Street address - No P.O. Boxes) (Apt. #) (City)

_____, _____, I lived at this location from ____/____/____ to ____/____/____.
(State) (Zip Code) (Month, Day, Year) (Month, Day, Year)

If you lived at the above address for less than 2 years or if you currently live at another address, attach an additional sheet of paper listing all other addresses at which you lived during the past two years and the dates (from/to) you lived there.

6. I have a Social Security Number ("SSN"): No Yes
 If you answered "yes" please provide your SSN _____
(-or- attach a copy of your card)

7. I have an Individual Taxpayer Identification Number ("ITIN") instead of a Social Security Number: No Yes
 If you answered "yes" please provide your ITIN _____
(-or- attach a copy of your card)

8. I am a Medicare beneficiary: No Yes
 If yes, please provide your Health Insurance Claim Number ("HICN"): _____
(-or- attach a copy of your card)

9. I have or had a Driver's License issued to me in a U.S. State or U.S. Territory: No Yes
 If yes, attach a legible photocopy of your driver's license
- and -
 List all other location(s) where you were licensed and provide driver's license number(s) where possible.

If you need more space attach an additional sheet listing your driver's license history

10. I was covered under health/medical insurance on the date of accident: No Yes
 If "yes" list:

Insurance Company: _____ Policyholder's Name: _____ Policy Number: _____

attach a copy of the front & back of your health/medical insurance card(s)



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11. Other people lived with me on the date of accident: No Yes
 If you answered "yes" **list everyone** that lived with you on the date of the accident:

First Name:	Middle Name:	Last Name:	Date of Birth:	Relationship to You:

If you need more space attach an additional sheet of paper listing the above information for everyone living with you.

12. Regarding the ownership of automobiles and motor vehicles, on the date of accident:
- a. I was the owner of a motor vehicle No Yes
 - b. I leased a motor vehicle No Yes
 - c. I had a motor vehicle **titled or registered** in my name No Yes
 - d. Someone that lived with me was the owner of a motor vehicle No Yes
 - e. Someone that lived with me leased a motor vehicle No Yes
 - f. Someone that lived with me had a motor vehicle **titled or registered** in their name No Yes

For each motor vehicle identified in the answers to question 12, attach copies of the registration(s) or title(s) and either the insurance card(s) or declaration page(s) of the insurance policies covering the vehicles on the accident date or provide the following information.

Owner:	Year:	Make:	Model:	License Plate#:	VIN #:	Insurer:	Policy #:

If you need more space, attach an additional sheet listing the vehicle information identified in question 12.

Claimant **must** sign this Affidavit. The Affidavit **must** be notarized. Read carefully before signing.

By signing this Affidavit, I declare and confirm that:

- All statements contained in this Affidavit and all documents provided are true and complete to the best of my knowledge.
- I understand that the requirements of all applicable statutes, rules, regulations and the Association's Decision Point Review Plan must be met before my eligibility for statutory benefits pursuant to N.J.S.A. 39:6-61 et seq. can be established.
- I am aware that if I knowingly file a statement of claim containing any false, inaccurate, misleading, or intentionally omitted information material to the claim that my claim will be denied and any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
- ***I understand the Association may disclose information about my claim to third parties to the extent the Association needs to do so in order to determine my eligibility for statutory benefits, in connection with any legal proceedings or prospective legal proceedings, in order to establish, exercise or defend its legal rights, for the purpose of fraud detection and prevention or as required and permitted to do so by law.***

Sworn to and subscribed before me this _____ day of _____, 20 _____

CLAIMANT NAME (Please Print)

NOTARY SIGNATURE

CLAIMANT SIGNATURE