

PROOF OF CLAIM

TENNESSEE INSURANCE GUARANTY ASSOCIATION

1600 Division Street, Suite 680

Nashville, TN 37203

(615) 242-6839 Fax (616) 255-4471 or (615) 255-4960 Website: www.tiga.net

THIS FORM MUST BE ATTACHED TO TOP OF CLAIM MATERIAL

***** PLEASE PRINT *****

I make a claim on the Tennessee Insurance Guaranty Association based on the following:

1. Nature of claim: _____
2. Date of Loss: _____ Claim Number: _____
3. Policy Number: _____
4. Insolvent Insurer: _____
5. Named Insured: _____
6. Name of Claimant: _____
7. Policy Deductible: _____
8. State of Residence or principal place of business (if other than individual) of named insured at date of loss:

9. List all other insurance coverage which may be available to the insured or claimant such as workers compensation, collision, med pay, uninsured motorist, or any other coverage (if none available, write "None"): _____
10. Are there any endorsements or side agreements including, but not limited to, assumption of Liability, Reinsurance Cut Through Endorsements or similar arrangements not stated in the declarations? _____ If so, please attach details.
11. Are there any self-insured retentions, deductibles, aggregates or similar arrangements **not stated** in the declarations ____? If so, please attach details.
12. Was your insurance ever cancelled, non-renewed or reinstated? If so, give dates and facts: _____ Use back if necessary.
13. On December 31, 20____ (on a consolidated basis for all affiliates and subsidiaries) did the insured's net worth exceed
\$10 Millionyes ?? no ?? (first party claims) **PLEASE CHECK BOX**
\$25 Millionyes ? no ? (third party claims) **PLEASE CHECK BOX**

ENCLOSE POLICY DECLARATIONS AND ALL ENDORSEMENTS. IF CLAIM IS RESULT OF LAWSUIT, ATTACH SUMMONS/COMPLAINT AND ANSWER IF AVAILABLE.

THIS CLAIM FORM CREATES NO LIABILITY OR OBLIGATION ON THE PART OF TIGA. IT IS BEING FURNISHED SOLELY TO DETERMINE ELIGIBILITY FOR COVERAGE AND ALL RIGHTS ARE EXPRESSLY RESERVED.

After being duly sworn, I certify under oath that this is a true and correct claim, that I personally have knowledge of the facts contained herein, and that, if a policyholder, my policy was paid up and in effect on the date of loss and was not cancelled or non renewed. I further affirm that I am not aware of any facts not set out above that may affect my coverage.

Named Insured or Claimant _____
Signature _____ Printed or typed Name _____

Address: _____

Telephone: _____

Agent's Name: _____

Agent's Address: _____

Agent's Telephone: _____

Sworn and subscribed before me this ____ day of _____, 20____.

Signature of Notary: _____

My commission expires: _____

NOTARY SEAL

CLAIM FORMS NOT NOTARIZED WILL BE RETURNED