

PROOF OF CLAIM

AMWEST SURETY INSURANCE COMPANY (IN LIQUIDATION)  
Claim Form for all Claims (Excluding Bond Loss Claims)

ALL CLAIMS MUST BE POSTMARKED BEFORE THE CLAIM FILING DEADLINE OF 5:00 P.M. CENTRAL DAYLIGHT SAVINGS TIME ON JUNE 7, 2002. READ CAREFULLY BEFORE COMPLETING. SEE INSTRUCTIONS ON BACK.

FOR OFFICE USE ONLY:		
Date Postmarked:		Interested Party Name:
Date Received:		Address:
Proof of Claim No.:		ID # Policy #
CLAIMANT INFORMATION		
Name:		Claimant: Please complete – Print (Black Ink) or Type Policy/Certificate No.:
Address (Include City, State & Zip Code):		Policy Period:
Home Telephone:		Insured:
Work Telephone:		Existing Claim No. (if any):
SSN or TIN:		Date Claim Incurred:
CLAIM INFORMATION		
All supporting documentation must be attached to Proof of Claim in order to be considered		
Claim is for:		Amount of Claim
Policyholder/Insured:		
_____ Claim is made for a specific loss or occurrence arising under coverage of the following type:		
_____	_____ Auto/Motorcycle physical damage/bodily injury	_____ Commercial Transportation
_____	_____ Other – Specify type: _____	_____ Homeowners
_____ Claim is made for the return of unearned premium due to early cancellation (If amount is unknown, Liquidator will calculate). Amount of premium/consideration paid to date _____. Attach copies of cancelled checks or other proof of payments. Was premium financed? _____ Yes _____ No		
If yes, provide premium finance company and details of premium financing _____		
All Other Claimants:		
_____ Claim is made against policyholder insured under the following type policy:		
_____	_____ Auto/Motorcycle physical damage/bodily injury	_____ Commercial Transportation
_____	_____ Other – Specify type: _____	_____ Homeowners
_____ Claim is made by an attorney for unpaid legal expenses.		
_____ Claim is made by a general creditor for unpaid invoices.		
_____ Claim is made by an agent or broker.		
_____ All others: state particulars of claim, including consideration given for this claim and attach supporting documentation; including a copy of written instrument which is the foundation of the claim.		
Please provide the exact amount of your claim and each component. Attach supplemental documentation, if available, to support your claim.		
TOTAL AMOUNT OF CLAIM:		\$
What payments have you received on this claim from Amwest? _____		
What securities or other collateral provided by Amwest do you hold? _____		
Do you assert any right of priority or other specific right with respect to your claim? _____		
STATUS OF CLAIM		
_____ Claim is based on a court judgment or settlement (attach order or agreement)		Name and address of your attorney, if any:
_____ Claim currently pending in court (provide details and documentation)		Name: _____
_____ Claim is not yet filed in court		Address: _____
_____ Other insurance is available to cover this claim		
_____ Claim previously reported to Amwest , Date Reported _____		City: _____ State: _____
_____ Claim being adjudicated or has been paid/settled by a State Property & Casualty Insurance Guaranty Fund		Zip Code: _____ Phone: _____
VERIFICATION		
The undersigned subscribes and affirms as true under penalty of perjury as follows:		
I have read the foregoing Proof of Claim and know the contents thereof; that this claim of \$ _____ against AMWEST SURETY INSURANCE COMPANY is justly owing to the claimant; that there is no set-off, counterclaim or defense to the claim thereto, except as above stated; that the matters set forth above and in any accompanying statements are true of my own knowledge except as to matters specifically stated to be alleged upon information and belief and that as to such matters, I believe them to be true; that no payment of or on account of the aforesaid claim has been made, except as stated above.		
Date Signed: _____		Print or Type Name of Claimant, Partner, Officer or Legal Representative
Subscribed and sworn to before me this _____ day of _____, 20____.		Signature of Individual, Partner, Officer or Legal Representative
Signature of Notary Public/Commissioner of Oaths		Title or Official Capacity
State of _____ County of _____		
My commission expires: _____		Home Phone ( ) _____
		Work Phone ( ) _____
		Social Security Number or FEIN of Claimant
(Seal)		

See reverse side for mailing and other instructions

Post Mark Date: \_\_\_\_\_  
POC No.: \_\_\_\_\_  
Date Received: \_\_\_\_\_  
RECOMMENDATION OF LIQUIDATOR:  
☐ Approval in full; ☐ Rejected;  
☐ Approval in the amount of \$ \_\_\_\_\_  
ACTION OF COURT: Approval in Amount of \$ \_\_\_\_\_

RETURN TO AMWEST