# NOTICE OF CLAIM

NORTH DAKOTA INSURANCE DEPARTMENT
STATE BONDING FUND
SFN 12199 (11-2019)

*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 | |
| Address | City | State | ZIP Code |
| Name of Bonded Employee and/or Official | | Social Security Number * | |
| 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 the completed form to:

North Dakota Insurance Reserve Fund
Bonding Fund
PO Box 2258
Bismarck, ND 58502

Telephone: 701-224-1988
Toll Free: 800-421-1988
Scan and Email to: BondingFund@NDIRF.com

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.