



# New Jersey Property-Liability Insurance Guaranty Association

New Jersey Surplus Lines Insurance Guaranty Fund  
Unsatisfied Claim and Judgment Fund  
Workers' Compensation Security Fund

233 Mount Airy Road ❖ Basking Ridge, New Jersey 07920  
Tel: (908) 382-7100  
www.njguaranty.org

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 the 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 an additional 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 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 Social Security 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 \_\_\_\_-\_\_\_\_-\_\_\_\_

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

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

11. Other people lived with me on the date of accident:  No  Yes  
 o 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 the 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 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 NJPLIGA’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 determined.
- 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 that NJPLIGA may disclose information about my claim to third parties as necessary to determine my eligibility for statutory benefits, in connection with any legal proceeding, to establish, exercise or defend its legal rights, for the purpose of fraud detection and prevention, or as otherwise required or permitted by law.***

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
CLAIMANT NAME (Please Print)

\_\_\_\_\_  
NOTARY SIGNATURE

\_\_\_\_\_  
CLAIMANT SIGNATURE