



# Michigan Property & Casualty Guaranty Association

PO Box 531266 · Livonia, Michigan 48153-1266 · Phone: (248) 482-0381

## STATEMENT OF CLAIM

This Statement of Claim is being filed with the Michigan Property and Casualty Guaranty Association ("MPCGA") by an individual or entity who is either an insured/policyholder or claimant for further consideration regarding a claim that arises under an insurance policy contract of the insolvent member insurer identified below. If more than one claimant, complete a separate Statement of Claim for each claimant. Additional forms can be found on the MPCGA website: [mpcga.org](http://mpcga.org).

The MPCGA is an association of all property and casualty insurers authorized to transact insurance in Michigan. The Association was created pursuant to the Property and Casualty Guaranty Association Act, MCL 500.7901 et seq. (the "Act"), to handle claims of insolvent member insurance companies to the extent those claims are "covered claims" under the Act.

### POLICYHOLDER INFORMATION:

name of insolvent insurance company	insurance company policy number	
name	address	city/state/zip

### CLAIMANT INFORMATION:

name (current & other name, if different on date of loss) ( )	address	city/state/zip	
phone number	social security number or federal tax ID	email address	date of birth

Name, address and phone number of attorney (if represented):

attorney name	( )	
address	city/state/zip	phone number

### CLAIM INFORMATION:

claim number	date of loss/incident	amount of claim, if known
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Claim description: *Give a concise statement of the facts below with relevant dates.*

### BASIS FOR CLAIM: Attach documents on which the claim is based.

- First Party Claim - Policyholder's claim arising out of a policy issued by the insurance company.
- Third Party Claim - Claimant with a claim against the policyholder who was insured by the insurance company.
- Workers' Compensation Claim - Employer's workers' compensation policy was issued by the insurance company.
- Unearned Premium Claim - Refund of the policy premium unearned.
- Other: \_\_\_\_\_

**Completion of this Statement of Claim does not indicate the claim is a "Covered Claim" under the Act. This Statement of Claim MUST BE RECEIVED by the MPCGA on or before the claim filing deadline set by the liquidation Court.**

IF YOU FAIL TO **SIGN AND DATE** THIS FORM, YOUR STATEMENT OF CLAIM WILL BE REJECTED. I DECLARE UNDER PENALTY OF PERJURY, UNDER THE LAWS OF THE STATE OF MICHIGAN, THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, EXECUTED THIS

\_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_ AT \_\_\_\_\_, \_\_\_\_\_  
day month year city state

POLICYHOLDER/CLAIMANT or THEIR ATTORNEY'S SIGNATURE	PRINT NAME AND TITLE (if any)
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**After completion, return this signed and dated Statement of Claim to: MPCGA • PO Box 531266 • Livonia, MI 48153-1266**

## CLAIM FILING INSTRUCTIONS

Please take a moment to review the definitions and information provided below that will assist you in filing the Statement of Claim with the Michigan Property & Casualty Guaranty Association (“MPCGA”).

### POLICYHOLDER INFORMATION

Name of insolvent insurance company: Complete the name of the insolvent insurance company.

Insurance company policy number: Provide the policy number on the policy issued by the insolvent insurance company (if known).

Name: Person or entity who is described as the insured on the policy declaration page issued by the insolvent company.

Address: The address of the policyholder. If the current address is different than the address provided on the policy, provide both addresses.

### CLAIMANT INFORMATION

Name: Provide the full name of the person who is filing a claim with the MPCGA. (If your name has changed since the date of date of loss or incident, please provide both your current and prior name).

Address: Provide your complete current address.

Phone/Email Address: Home, Mobile and if applicable your work phone number. Email – provide if you wish to be contacted by email.

Social Security/DOB: Your individual social security number and date of birth. For business entities, provide the Federal Tax ID number.

Attorney Information: Provide the name, address and telephone number if you are represented by an attorney.

### CLAIM INFORMATION

Claim Number: Provide the prior assigned claim number by the insolvent insurance company (if known).

Date of Loss/Incident: Provide the date of loss/incident took place for the claim being presented.

Amount of Claim: Indicate the dollar amount of the claim being filed, if known. If unknown, indicate “unknown”.

Claim Description: A brief description that outlines how the claim occurred, damages sustained and the basis for filing a claim with the MPCGA.

**BASIS FOR CLAIM** - You must choose one box

First Party Claim: If you are a policyholder filing a claim under the policy you purchased from the insolvent company.

Third Party Claim: If you are filing a claim against a policyholder of the insolvent insurance company.

Workers’ Compensation Claim: If you are filing a work-related claim as an employee/employer of a policyholder who had workers’ compensation insurance with the insolvent insurance company.

Unearned Premium: If you are a policyholder making a claim for a refund of premiums paid because of a policy cancellation caused by the company’s insolvency.

Other: If filing a claim not described above, include a description and the type of claim being filed.

**Please attach any documents that you believe will support your claim.**

### SIGNATURE & DATE

The person filing this claim must sign and date the form. If you fail to sign and date this form, your Statement of Claim will be rejected.

### FILING YOUR CLAIM WITH THE MPCGA

The signed, dated and completed form along with the supporting documents must be mailed as noted on the Statement of Claim form. It is suggested you make a copy for your records.