CLAIM AFFIRMATION FORM

The undersigned claimant certifies, under penalty of perjury, the claimant has read the claim and knows the contents thereof and the claimant is the owner of the said claim and the person entitled to receive the money set forth in said claim.

The claimant agrees to indemnify and hold harmless the State, the Courts and its agents, officers, and employees from any loss resulting from the payment of said claims.

CURRENT INFORMATION AND SIGNATURE MUST BE PROVIDED FOR EACH CLAIMANT OR YOUR CLAIM WILL NOT BE PROCESSED.

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Claimant's Information:

<table>
<tr><td colspan="3">CASE DOCKET NUMBER OR CHECK NUMBER</td><td colspan="3">REIMBURSEMENT CLAIM AMOUNT</td></tr>
<tr><td>LAST NAME OR BUSINESS</td><td>FIRST NAME</td><td>MIDDLE INITIAL</td><td colspan="2">SSN OR FEDERAL TAX ID</td><td>DATE</td></tr>
<tr><td colspan="6">CURRENT PHOTO ID Ex. Driver's License, Passport, or Identification Card (PLEASE ATTACH A COLOR COPY TO CLAIM)</td></tr>
<tr><td colspan="2">CURRENT MAILING ADDRESS</td><td>CITY</td><td>STATE/PROVINCE</td><td>ZIP</td><td>COUNTRY</td></tr>
<tr><td>DAYTIME PHONE</td><td colspan="5">CLAIMANT OR AUTHORIZED AGENT SIGNATURE</td></tr>
</table>

YOUR SIGNATURE MUST BE NOTARIZED IF THE CLAIM AMOUNT IS $1,000 OR GREATER
For claims filed for a business, the authorized owner's signature is required. For claims filed for an estate or trust the signature of the executor, administrator or attorney is required.

State of California
County of Stanislaus

Subscribed and sworn to (or affirmed) before me on this ____day of _______, 20___, by _____________, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Signature___________________ (seal)

PRIVACY NOTIFICATION
Your Social Security number and other documents are requested for identification and processing of your claim.

CLAIM FOR REIMBURSEMENT

MAIL TO: **Superior Court of California, County of Stanislaus**
Fiscal Services – Escheatment Personnel
PO BOX 732
Modesto, CA 95353

TODAY'S DATE: ______________________________

CASE DOCKET NUMBER or CHECK NUMBER: ______________________________

OWNER'S NAME: ______________________________

STREET ADDRESS: ______________________________

CITY, STATE, ZIP CODE: ______________________________

REIMBURSEMENT CLAIM AMOUNT: ______________________________

NAME OF THE PERSON FILLING OUT THIS FORM AND YOUR RELATIONSHIP TO THE OWNER:

____

HOLDER'S USE ONLY (*Completed by Court Employee)*

Warrants were paid to the holder shown below:

Superior Court of California, County of Stanislaus

Fiscal Services – Escheatment Personnel
PO BOX 732
Modesto, CA 95353

Tax Identification Number: ______________________________

Reason for claimed reimbursement:

____

A SEPARATE FORM IS REQUIRED FOR EACH ACCOUNT FOR WHICH REIMBURSEMENT IF CLAIMED.

AFFIRMATION AND SIGNATURE

I hereby affirm, under penalty of perjury, that I am an authorized agent of the holder named in this Claim for Reimbursement and duly authorized to make said claim upon the Superior Court of California, County of Stanislaus. The above-named holder hereby agrees to indemnify and hold harmless the State, the Courts, its officers and employees from any loss as a result of payment of the amount claimed.

Signature: ______________________________ Date: ________________________

(Claimant's Signature)