



DEPARTMENT OF FINANCIAL SERVICES

Division of Rehabilitation and Liquidation

www.floridainsurancereceiver.org

INACTIVE or DISSOLVED COMPANY with ESTATE AFFIDAVIT for NAME/ADDRESS CHANGE REQUEST

After being duly sworn, the Affiant states as follows:

1. My name is _____. I have personal knowledge of the matters set forth in this affidavit, and if called to testify would do so as set forth herein.
2. I am _____ years of age.
3. My current address is _____.

(*Insert name of Inactive or Dissolved company)

4. * _____ is currently dissolved. (corporations, only)
5. I was the sole owner and proprietor of * _____.
6. * _____ has not been subject to a U.S. Bankruptcy Code proceeding.
7. No rights or interest in * _____ have been subject to disposition in a dissolution of a marriage proceeding.

(*Insert deceased claimant's name)

8. I am the sole beneficiary of the estate of * _____.
9. My relationship to * _____ is _____.

(*Insert Receiver Claim Number and name of Receivership Company from the request form)

10. I am the sole person who is entitled to any funds resulting from receivership id# * _____ in the estate of (not deceased person) * _____.
11. I agree to allow my name and address to be provided to any subsequent claimants who come forward with proof to claim entitlement to these funds.
12. I agree to hold harmless the Department of Financial Services and the Division of Rehabilitation and Liquidation should subsequent claimants come forward with proof to claim entitlement to these funds.

I swear or affirm that I am the claimant referenced in the mailing address on this form and/or am authorized to sign this form on the claimant's behalf. I further swear under penalty of law that all information contained on this form as well as all attachments are true and correct to the best of my knowledge.

 (Affiant Signature) (Affiant Printed Name)
 State of _____ County of _____
 Sworn to and subscribed to me by _____ on this ____ day of _____, 20____.

Notary Signature _____