IdenTrust part of HID Global	**IDENTRUST CLAIM-LOSS FORM**	**CLAIM NO. ASSIGNED:**	

PART I – TO BE COMPLETED BY CLAIMANT

1. NAME OF PERSON FILING CLAIM FORM *(Last, First, Middle Initial)*	**2. COMPANY / CLAIMANT NAME (IF DIFFERENT)**
3. ADDRESS FOR CORRESPONDENCE *(Street, City, State and Zip Code)*	**4. OCCUPATION / TITLE / RELATIONSHIP TO CLAIMANT**

5. OFFICE PHONE NO. *(Include Area Code)*	**6. CELL PHONE NO.** *(Include Area Code)*	**7. FACSIMILE NO.** *(Include Area Code)*
8. YOUR E-MAIL ADDRESS	**9. DATE OF OCCURRENCE**	**10. DATE LOSS WAS DISCOVERED**
11. TYPE OF CERTIFICATE INVOLVED	**12. CERTIFICATE ISSUANCE DATE**	**13. AMOUNT OF LOSS CLAIMED** $
14. SUBSCRIBER'S NAME IN CERTIFICATE	**15. SUBSCRIBER'S NAME (IF DIFFERENT)**	**16. SUBSCRIBER'S E-MAIL ADDRESS**

17. CIRCUMSTANCES SURROUNDING LOSS *(Explain in detail. Include relevant dates, times and places. Use additional sheets if necessary.)*

	Yes	No
18. HAVE YOU OR ANYONE ON YOUR BEHALF CONDUCTED AN INVESTIGATION INTO THE CAUSE OF THE LOSS? *(If "Yes," please provide evidence that you conducted a thorough investigation and that you have suffered a recoverable loss due to reasonable reliance on a certificate, or due to IdenTrust's breach of contract or failure to perform.)*		
19. DID YOU HAVE PRIVATE INSURANCE COVERING YOUR LOSS? *(If "Yes," please provide the name of the insurer and Policy Number. Attach a copy of the policy if you have one.)*		
20. HAVE YOU MADE A CLAIM AGAINST YOUR PRIVATE INSURER? *(If "Yes," attach a copy of your correspondence. If you have insurance covering your loss, you must submit a claim with the insurer before you may make a claim to IdenTrust.)*		
21. DID YOU CHECK TO SEE IF THE CERTIFICATE HAD EXPIRED OR BEEN REVOKED? *(If "Yes," please indicate whether validity was checked via CRL or OCSP and the date and time that this was done. Include any evidence with this form.)*		
22. WAS A POLICE REPORT FILED? *(If "Yes," please attach a copy of the report.)*		

23. WITNESS #1 *(Last, First, Middle Initial)*	**24. WITNESS #2** *(Last, First, Middle Initial)*
25. ADDRESS *(Street, City, State and Zip Code)*	**26. ADDRESS** *(Street, City, State and Zip Code)*
27. TELEPHONE NO. *(Include Area Code)*	**28. TELEPHONE NO.** *(Include Area Code)*

29. If there are any other important or relevant details related to this claim, please provide them here:

UNDER PENALTY OF LAW, I CERTIFY IN SUBMITTING THIS CLAIM THAT to the best of my knowledge and belief, the information contained in this claim represents all material facts and is true. I understand that misrepresentation of facts is subject to prosecution under Federal law.

30. _____ **DATE** *(MM / DD / YYYY)*

31. _____ **SIGNATURE OF CLAIMANT** *(or Designated Agent)*

PART II –CLAIMS APPROVAL *(To be completed by the IdenTrust Claims Officer)*

AMOUNT AWARDED. The claim is cognizable and meritorious; the claimant is a proper claimant; the loss has been verified in accordance with applicable procedures as prescribed by controlling law.	$

_____ **DATE** *(MM / DD / YYYY)*

_____ **SIGNATURE OF CLAIMS OFFICER**

IdenTrust part of HID Global	**IDENTRUST CLAIM-LOSS FORM**	**CLAIM NO. ASSIGNED:**	

PURPOSE

The purpose of the IdenTrust Claim-Loss Form is to collect information regarding the legal basis for the administrative payment of claims against IdenTrust related to its performance of Certification Authority functions. The information may also be used to obtain collection from third parties, including Subscribers and insurers, or to investigate fraud.

INSTRUCTIONS

1. You must submit your claim in writing not later than one year after the date of discovery of the facts out of which the claim arose. This one-year time limitation may not be waived.

2. IdenTrust requests that you make a thorough investigation of the circumstances giving rise to your claim. If you notify IdenTrust, we will cooperate reasonably in that investigation.

3. The claimant or an authorized agent must complete and sign Part I of this form, answering all questions. If the claim is signed by an agent or representative of the claimant, that person must have a document showing his or her authority to present the claim, such as a power of attorney, etc.

4. After completing the form, please return it to:
   Attn: Claims Officer, IdenTrust Services, LLC.
   5225 Wiley Post Way, Suite 450
   Salt Lake City UT 84116

Or fax to: 1 (801) 384-3610

5. Please provide reasonable documented proof:
   - That the claimant has suffered a recoverable loss as a result of an IdenTrust-issued certificate;
   - Of the amount and extent of the recoverable loss claimed; and
   - Of the causal linkage between the alleged transaction and the recoverable loss claimed, itemized as necessary.

6. Upon receipt of your claim, the IdenTrust Claims Officer will determine whether to pay the claim, in whole or in party, or deny it. The IdenTrust Claims Officer will notify the Claimant of its determination within 30 days of receipt of the claim form. If no response is received within said 30 days, the claim shall be deemed denied.

7. If Claimant is not satisfied with IdenTrust's treatment of the claim, the Claimant may appeal the decision to the IdenTrust Appeals Officer or to a court of competent jurisdiction within 30 days of the decision.

PART III - DENIAL OR SUPPLEMENTAL PAYMENT *(To be completed by IdenTrust Appeals Officer)*

	DENIAL *(X if applicable)*		**SUPPLEMENTAL PAYMENT** *(X and complete if applicable)*	
	The claim is not cognizable nor meritorious under the provisions of the Certification Practice Statement or other related documents and the claim is therefore denied.		The claim is cognizable and meritorious and the following additional award has been substantiated:	$

DATE *(MM / DD / YYYY)*

SIGNATURE OF IDENTRUST APPEALS OFFICER

Additional reasons for Denial or Approval of Supplemental Payment, if any.