



CLAIM FORM

(Please print clearly if not typed in order to avoid errors.
All blanks must be completed in order to be accepted.)

This claim is for: (name injured party)			
Your name:			
Address:			
City/State/Zip:			
Tel:		Email:	
Relationship to injured party:			
Type of Claim:	<input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> African Slavery <input type="checkbox"/> Japanese American <input type="checkbox"/> Alaska Aleut <input type="checkbox"/> Tuskegee Experiments <input type="checkbox"/> Forced Sterilizations		
How do you prefer to receive payment:	<input type="checkbox"/> Check <input type="checkbox"/> Opt Out	<input type="checkbox"/> Direct Deposit	<input type="checkbox"/> Donate Back
What do you feel is most Needed in your community:	<input type="checkbox"/> Parks <input type="checkbox"/> Playgrounds <input type="checkbox"/> Transportation <input type="checkbox"/> Other _____	<input type="checkbox"/> Housing <input type="checkbox"/> Gardens <input type="checkbox"/> Healthcare	<input type="checkbox"/> Education <input type="checkbox"/> Roadways <input type="checkbox"/> Law Enforce
<p>I certify that the information provided on this form and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I declare under penalty of perjury that the foregoing is true and correct. I understand that false statements or claims made in connection with the claim form may result in fines, imprisonment and/or any other remedy available by law to the federal government, including as provided in 18 U.S.C. § 1001, and that claims that appear to be potentially fraudulent or to contain false information will be forwarded to the federal, state and local law enforcement authorities for possible investigation and prosecution.</p>			
Date:	Signature:		