

Claimant _____
Claim No. _____
Estate _____
Adjuster _____

AFFIDAVIT REGARDING OTHER INSURANCE

STATE OF TEXAS:

COUNTY OF _____

BEFORE ME, on this day personally appeared **[claimant]**, who first being duly sworn did upon **[his/her]** oath depose and said:

1. "My name is _____. I am over the age of 18. I am of sound mind and have never been convicted of a felony or a crime involving moral turpitude. I have personal knowledge of the facts stated herein and am competent to make this Affidavit.
2. My contact phone is _____. E-mail : _____.
3. My social security number is _____.
4. I made a claim against **[insured/impaired insurer]** for an incident that occurred on **[date of loss]**. I recognize that **[impaired insurer]** has been placed into receivership and that I must first exhaust my rights under all other available insurance before proceeding against the guaranty association. I understand that the term "other insurance" includes, but is not limited to, indemnity and medical benefits under a workers' compensation policy, health, disability, uninsured and/or underinsured motorist, personal injury protection, medical payment, liability, or other policy. If I or any person in my family worked at the time of the accident, I understand that my or their employer may have had insurance that provided coverage to me for the injuries, damages and disabilities I may have sustained, and I understand that I must exhaust all available insurance carried by my or their employer that may have provided coverage to me, including, but not limited to, general liability insurance, the employers' automobile insurance, workers' compensation insurance, and health insurance plans administered or run by the employer.
5. At the time of the incident made the basis of my claim, the following policies of insurance were in effect that might be applicable to this claim. I have listed all such insurance policies, policy limits, claim numbers, amounts received, named insures, policy periods and types of coverage on a separate document, attached to this affidavit as Exhibit "A". Exhibit "A" is fully incorporated as an integral part of this affidavit, and I swear that the information contained in Exhibit "A" is true.
6. For all of the policies of insurance I have listed above or in Exhibit "A", I have attached a correct copy of the declaration page or pages to my affidavit. The attached declaration page or pages form an integral part of my affidavit, and I

swear that the information contained in the attached declaration page or pages is or are true.

7. To date, I have received payments of benefits in the total amount of \$_____ for injuries, damages, and/or disabilities caused by the incident made the basis of my claim from other insurance policies that provided coverage to me for the incident made the basis of my claim against **[insured/TPCIGA]**.
8. I do not have any additional insurance coverage for the incident made the basis of my claim against **[insured/TPCIGA]** other than under the policies listed in Exhibit "A".
9. I further agree that if additional information regarding other available insurance becomes available to me or my agent, I or they will immediately contact the Texas Property and Casualty Insurance Guaranty Association.
10. I have attached a letter from my employer and/or the employer of my family member stating the insurance coverages and benefits available to me through that employer, if any.
11. I understand that I have sworn to tell the truth in this affidavit. I have read everything contained in my affidavit and under penalty of perjury I swear that everything is true and complete to my knowledge.
12. I understand that if I have made a false representation or failed to disclose other insurance information, it may jeopardize my right to recover from the Texas Property and Casualty Insurance Guaranty Association.

[Claimant]

Sworn to and signed before me on the _____ day of _____, _____.

Notary Public in and for the State of Texas

EXHIBIT "A"
TO AFFIDAVIT REGARDING OTHER INSURANCE

INSTRUCTIONS: The following policies might be applicable to the incident made the basis of claim against **[insured/TPCIGA]**. For each policy listed, I have included all forms of coverage (i.e. liability, UM, comprehensive, PIP, etc.). Even if I am unsure whether or not a policy provides coverage, I am listing that policy.

Personal Health Insurance and/or Disability Policy

a. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Employer's of Family Member's Employer's Health Insurance Policy

b. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Worker's Compensation Coverage

c. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Auto Liability Insuring Any Other Party Involved in the Accident

d. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Your Personal Auto Policy

e. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Auto Policy of Driver of the Vehicle You Were In

f. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____

Auto Policy of Owner of the Vehicle You Were In

g. Name and address of insurance carrier: _____

Policy No. : _____
Policy Limits : _____
Claim No. : _____
Named Insured : _____
Policy Period : _____
Type of Coverage : _____
Amount received
under this policy : _____

Auto Policy With UM, MedPay or PIP of Any Family Member

h. Name and address of insurance carrier: _____

Policy No. : _____
Policy Limits : _____
Claim No. : _____
Named Insured : _____
Policy Period : _____
Type of Coverage : _____
Amount received
under this policy : _____

Other Policies

i. Name and address of insurance carrier: _____

Policy No. : _____

Policy Limits : _____

Claim No. : _____

Named Insured : _____

Policy Period : _____

Type of Coverage : _____

Amount received
under this policy : _____