CITY OF SAN BERNARDINO
FINANCE DEPARTMENT
290 North D Street, 3rd Floor
SAN BERNARDINO, CALIFORNIA 92401
TELEPHONE: (909) 384-5242 FAX: (909) 384-5043
www.ci.san-bernardino.ca.us/unclaimedfunds

CLAIM FORM - UNCLAIMED FUNDS

Original Payee Name: ____

Claimant Name: ______________________________ **Phone #:** ____________________
(if different)

Current Address: ____
____

DL#:__________________ **SS#/TIN:**____________________ **Phone #:** ____________________

(Individuals: please attach a copy of your driver's license)

Address when check was written: ____
____

Reason for original check issue (if known): ____
____

Original Check: Date:______________________________ **Amount:**______________________________

In order to process a replacement check and claim these funds, the City of San Bernardino Director of Finance must receive this form

In consideration thereof, it is agreed that the undersigned, the heirs, executors, successors or assigns of the undersigned, will indemnify and hold harmless the City of San Bernardino, or assigns, from and against any and all claims, liability, loss, damage, expenses, counsel fees and costs arising through or by reason of any endorsement, presentation, negotiation, collection or any attempt at collection or negotiation of the Original Check or the Replacement Check by the undersigned, the employees, or agents of the undersigned. In the event the Original check shall be found, the undersigned agrees to deliver to cause the same to be delivered to the City of San Bernardino for cancellation and to reimburse the City of San Bernardino for all expenses incurred by reason of the issuance of the Replacement Check.

Authorized Signature: ______________________________ **Date:** ____________________

Name (Print): ______________________________ **Title:** ____________________

Please mail back to: City of San Bernardino
Attn: Finance Department – Unclaimed
Funds 290 North D Street, 3rd Floor
San Bernardino, CA 92401

City of San Bernardino Use Only

Finance

- ☐ Confirmed item on outstanding check list Name/Date: ______________
- ☐ Input & Processed claim Name/Date: ______________
- Replacement Check: Check # ______________ Check Date: ________
- ☐ Check if O/S at bank ______________
- ☐ Void check at bank ______________
- ☐ Authorize reissue of check ______________