

FOR OFFICE USE ONLY

Claim No. W- \_\_\_\_\_

Receivership \_\_\_\_\_

## GRAIN DEPOSITORS AND SELLERS INDEMNITY FUND WAREHOUSE CLAIM FORM

Name and Address of warehouse under which claim arose:

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1. Depositor's Name: \_\_\_\_\_ (FIRST \ MIDDLE \ LAST) By: \_\_\_\_\_ (NAME & TITLE)

2. Address: \_\_\_\_\_  
Street or Box No. City State Zip Code

3. Telephone No.: ( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code

4. Social Security or Fed. Tax I.D. No. \_\_\_\_\_

5.

DATE OF DELIVERY	SETTLEMENT SHEET OR SCALE TICKET NUMBER	WAREHOUSE RECEIPT NUMBER	TYPE OF GRAIN	TOTAL (GROSS) BUSHELS	REMAINING (PARTIAL) BUSHELS

6. Please indicate each item of documentation you are attaching to this claim:

Scale Ticket

Settlement Sheet

Warehouse Receipt

**7. Options for payment (check one only)**

Payment from Indemnity Fund first: Treat this claim as a joint claim against the Indemnity Fund and any receivership by the Department in regard to this warehouse, but I elect to present my claim first against the Fund for payment of 90% of the loss up to \$300,000, with the remaining 10% to be presented as a claim in the receivership for pro rata payment, if any. I understand that in receiving payment from the Fund, that portion of my claim in the receivership will be assigned to the Fund.

Payment from the Receivership first: Treat this claim as a joint claim against the Indemnity Fund and any receivership by the Department in regard to this warehouse, but I elect to present my claim first against the receivership for pro rata distribution on the claim, with the remaining loss to be presented as a claim against the Fund for payment of 90% of the remaining loss up to \$300,000. I understand that no payment can be made from the receivership before a minimum of 120 days and that all payments are subject to court approval.

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8. I, \_\_\_\_\_  
(Print full name or names)

being duly sworn, state under penalty of perjury that the information stated in and attached to this claim is true and correct to the best of my knowledge. If a partnership, I further state that I am authorized to file this claim on behalf of the partnership.

\_\_\_\_\_  
(Signature) (Title \ Position)

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC IN AND FOR  
THE STATE OF \_\_\_\_\_

ALL CLAIM FORMS MUST BE NOTARIZED AND RETURNED TO:

**IOWA DEPARTMENT OF AGRICULTURE AND LAND STEWARDSHIP  
GRAIN WAREHOUSE BUREAU  
WALLACE STATE OFFICE BUILDING  
DES MOINES, IOWA 50319**

**ALL CLAIMS MUST BE FILED NO LATER THAN 120 DAYS FOLLOWING REVOCATION, TERMINATION, OR CANCELLATION OF THE WAREHOUSE LICENSE WITH THE IOWA DEPARTMENT OF AGRICULTURE AND LAND STEWARDSHIP (Address stated above).**