GEORGE KAITSA

Delaware County Auditor
Fiscal Services Division
140 N Sandusky Street, Delaware, OH 43015
740 - 833- 2920

The undersigned makes claim to Unclaimed Funds now in the custody of the Delaware County Auditor's Office in the amount and kind as specified below, pursuant to Chapter 9.39 of the Ohio Revised Code.

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY. FAILURE TO DO SO WILL DELAY THE PROCESSING OF THE CLAIM.

Please Print or Type

Original Owner of the Funds		**Claimant's Name**	
Original Owner's Address		**Claimant's Address**	
Original Owner's Phone Number		**Claimant's Phone Number**	
Original Owner's Social Security Number or Tax ID		**Are you the original owner of these funds?**	
		___Yes ___No	
Amount of Unclaimed Funds	**Code**	Are you a paid professional finder? If yes, a Power of Attorney is required	
$		___ Yes ___No	
Original Owner's Signature		Unclaimed check number	Unclaimed Check Date

Please attach the following to this form:

- A clear photocopy of a document with the original owner's name and Social Security number on it, such as a Social Security card, driver's license, or State of Ohio ID. *REQUIRED FOR ALL CLAIMS*. (The Social Security number will be held in the strictest confidence and used only to establish rightful ownership of the unclaimed funds.)
- The original check (s) – IF AVAILABLE.
- A Power of Attorney signed by the original owner *or* copies of the death certificate and letter of authority naming the executor of the estate. The Auditor's office reserves the right to contact the original payee directly to confirm a Power of Attorney.

THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC

Under penalties of perjury, I certify that the information provided on this claim form is true and correct and all supporting documents presented are original or true unaltered copies of the original documents. I also certify that I have a legal or equitable interest in the Unclaimed Funds and will indemnify and save harmless Delaware County, Ohio, and its employees from any damages, claims, or losses of any kind resulting from payment of the above described funds to claimant. If claiming on behalf of a business, print and sign both your name and the business name below.

X Claimant Signature ____ Date ____________

Please Print or Type Claimant's Name ____

State of ______________________________ County of ____________________

Subscribed and sworn to before me this ______________ day of _________________, 20 ________

____
Notary Public Signature