PRINT SAVE AS

UNITED STATES VIRGIN ISLANDS

EMAIL

DEPARTMENT OF PLANNING AND NATURAL RESOURCES

DIVISION OF FISH & WILDLIFE

NOAA/ DPNR-USVI FISHERIES DISASTER ASSISTANCE PROGRAM

-

INSURANCE CERTIFICATION FORM

***MANDATORY FOR ALL ABOVE BASE PAYMENT APPLICANTS ***

****FOR OFFICIAL USE ONLY / DO NOT WRITE BELOW****

DPNR APPLICANT RECORD LOCATOR INFORMATION

FULL NAME: _____

DISTRICT: _____

DPNR RECORD LOCATOR #: _____

A. APPLICANT/ OWNER/ ENTITY INFORMATION ***

Last Name: * _____**
First Name: * _____**
Middle Name or Initial: * _____**
Full Business Name (If applicable): * _____**
Business License Number or S-S-N Number: * _____**
Mailing Address1: * _____**
Mailing Address2: _____
City: * _____**
State: * _____**
Zip Code: * _____**
Primary Phone Number: * _____**
Email Address: * _____**
USVI District Designation: * _____**

B. CERTIFICATIONS *** [PLEASE CHOOSE ONE (1) BELOW]

☐ I CERTIFY THAT NONE OF THE ITEMS THAT I HAVE DOCUMENTED AS POTENTIALLY ELIGIBLE FOR FEDERAL FUNDS ABOVE THE BASE PAYMENT AMOUNTS, WERE NOT INSURED BY ANY PROPERTY OR CASUALTY INSURANCE COMPANY APPROVED TO CONDUCT BUSINESS IN THE UNITED STATES VIRGIN ISLANDS DURING THE PERIOD OF 2017 DURING HURRICANES IRMA/ MARIA: ***

☐ I CERTIFY THAT ALL INFORMATION PERTAINING TO THE INSURANCE PROVIDER AND COVERAGE FOR ITEMS POTENTIALLY ELIGIBLE FOR FEDERAL FUNDS ABOVE THE BASE PAYMENT AMOUNTS, WERE IN FACT INSURED BY A PROPERTY OR CASUALTY INSURANCE COMPANY APPROVED TO CONDUCT BUSINESS IN THE UNITED STATES VIRGIN ISLANDS DURING THE PERIOD OF 2017 DURING HURRICANES IRMA/ MARIA: ***

PLEASE NOTE THAT IF YOU HAVE LISTED FISHING TRAPS AS DAMAGED OR DESTROYED GEAR, YOU MUST PROVIDE REGISTRATION INFORMATION FOR ALL TRAPS THAT WERE DAMAGED OR DESTROYED AS A RESULT OF HURRICANES IRMA/ MARIA.

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*****MANDATORY FOR ALL ABOVE BASE PAYMENT APPLICANTS *****

INSURANCE CLAIM 1

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE COMPANY AGENT'S NAME: _____

INSURANCE POLICY NUMBER: _____

DATE INSURANCE CLAIM FILED: _____

AMOUNT OF CLAIM PAID: _____

DATE OF INSURANCE PAYMENT: _____

ASSETS COVERED IN INSURANCE CLAIM (LIST ALL) ITEM(S)	$$$ Amount	% Amount
1:		
2:		
3:		
4:		
5:		
6:		
7:		
8:		
9:		
10:		
TOTAL(S):		

ASSETS COVERED IN FINAL INSURANCE CLAIM PAYMENT (LIST ALL) ITEM(S)	$$$ Amount
1:	
2:	
3:	
4:	
5:	
6:	
7:	
8:	
9:	
10:	
TOTAL:	

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INSURANCE CERTIFICATION FORM

***MANDATORY FOR ALL ABOVE BASE PAYMENT APPLICANTS ***

INSURANCE CLAIM 2

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE COMPANY AGENT'S NAME: _____

INSURANCE POLICY NUMBER: _____

DATE INSURANCE CLAIM FILED: _____

AMOUNT OF CLAIM PAID: _____

DATE OF INSURANCE PAYMENT: _____

ASSETS COVERED IN INSURANCE CLAIM (LIST ALL)

ITEM(S)	$$$ Amount	% Amount
1:		
2:		
3:		
4:		
5:		
6:		
7:		
8:		
9:		
10:		
TOTAL(S):		

ASSETS COVERED IN FINAL INSURANCE CLAIM PAYMENT (LIST ALL)

ITEM(S)	$$$ Amount
1:	
2:	
3:	
4:	
5:	
6:	
7:	
8:	
9:	
10:	
TOTAL:	

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INSURANCE CERTIFICATION FORM

***MANDATORY FOR ALL ABOVE BASE PAYMENT APPLICANTS ***

INSURANCE CLAIM 3

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE COMPANY AGENT'S NAME: _____

INSURANCE POLICY NUMBER: _____

DATE INSURANCE CLAIM FILED: _____

AMOUNT OF CLAIM PAID: _____

DATE OF INSURANCE PAYMENT: _____

ASSETS COVERED IN INSURANCE CLAIM (LIST ALL)

ITEM(S)	$$$ Amount	% Amount
1:		
2:		
3:		
4:		
5:		
6:		
7:		
8:		
9:		
10:		
TOTAL(S):		

ASSETS COVERED IN FINAL INSURANCE CLAIM PAYMENT (LIST ALL)

ITEM(S)	$$$ Amount
1:	
2:	
3:	
4:	
5:	
6:	
7:	
8:	
9:	
10:	
TOTAL:	

C. SIGNATURE ***

I hereby certify that the information provided herein by me is true and correct and, by my signature on this document, acknowledge my understanding that any intentional or negligent misrepresentation or falsification of any of the information in this document could subject me to disqualification from participation and punishment under federal, resulting in civil liability and/or in criminal penalties, including but not limited to, fine or imprisonment or both under Title 18, United States Code, Sec. 1001, et seq. and punishment under federal law.

By my signature below, I authorize verification or re-verification of any information contained herein by the grant administering agency (VIDPNR), its agents, successors, and assigns either directly or through a third-party source.

_____
GRANTEE'S PRINTED NAME

X _____ _____ _____
GRANTEE'S SIGNATURE | DATE | PHONE NUMBER