September 11th
Victim Compensation Fund

Claim Information Resolution Form

This form should be used by claimants to clarify a discrepancy in the information submitted with a claim. **If the VCF contacted you about a discrepancy with your claim, we cannot continue with the processing of your claim until you complete and return this form.**

You may mail, fax, or upload this form to your claim. If you need assistance completing this form, please call our toll-free Helpline at 1-855-885-1555.

Note: If you upload the completed form to your claim, select the "**Claim Information Resolution Form**" document type.

Victim/Claimant Information (required)

VCF Claim Number: VCF (Input the 7 numbers after VCF)

Victim/Claimant Full Legal Name

_____

First Name *Middle Name* *Last Name*

Victim Social Security Number: _____

Date of Birth (mm/dd/yyyy): _____

Personal Representative Information (*required only if victim is deceased*)

Personal Representative Full Legal Name

_____

First Name *Middle Name* *Last Name*

Social Security Number: _____

Date of Birth (mm/dd/yyyy): _____

Signature (required) – *By signing below, I authorize the VCF to make the necessary updates to my claim.*

_____ _____

Victim/Claimant Signature **Date**