



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

MARYLAND BOARD OF MORTICIANS AND FUNERAL DIRECTORS
FAMILY SECURITY TRUST CLAIM FORM
(Requirements per Health Occupations 7-4A-07(b) (1) and COMAR 10.29.15)

Please provide the following in order for the Board to evaluate your Family Security Trust Fund claim:

Maryland Funeral Establishment where the pre-need agreement was signed: \_\_\_\_\_

Funeral Establishment Address: \_\_\_\_\_

Name and position (if known) of individual with whom the claimant entered into pre-need trust account: \_\_\_\_\_

Amount Deposited: \_\_\_\_\_ Date of Deposit: \_\_\_\_\_ Amount of Loss: \_\_\_\_\_

Describe the event(s) that lead to the monetary loss. Include as much detail as possible, including date loss was first noticed, description of any supporting documentation, name and current situation for whom the pre-need agreement was established, and your relationship, if different from yourself.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Continue on separate sheet, if necessary)

I hereby certify under penalty of perjury that the above information is true and correct to the best of my knowledge, and that this claim is made in good faith. I understand that the Board may conduct an investigation of this claim. I understand the Board may set a hearing in accordance with the hearing procedures in Md. Code, Ann., Health Occupations ("Health Occ.") Article, § 7-319; Health Occ. § 7-4A-09; and Md. Code, Ann., State Government Article, § 10-201 et. seq.

YOUR SIGNATURE MUST BE WITNESSED BY A NOTARY PUBLIC

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Your Address: \_\_\_\_\_

Your email(s): \_\_\_\_\_

Signed before me on Date: \_\_\_\_\_ BY: \_\_\_\_\_

Signature of Notary Official: \_\_\_\_\_

STAMP:

Title of Office: \_\_\_\_\_

My commission expires: \_\_\_\_\_

Please return this form and any supporting documentation to
4201 Patterson Ave, Baltimore, MD 21215, or scan and send to mdhbomfd@maryland.gov