



State Bar Association
of North Dakota

CLIENT PROTECTION PROGRAM CLAIM FORM

Your Name: _____

Address: _____

Phone Number: _____

Name and address of attorney in question:

1. Did the loss occur in the last two years? ☐ Yes ☐ No
2. What is the claimed date of loss? _____
3. Was your loss caused by theft, embezzlement or fraud? ☐ Yes ☐ No
3. Was the alleged embezzlement or fraud done in North Dakota by **your** attorney?
☐ Yes ☐ No
4. Have you filed a claim with the Disciplinary Counsel against this attorney?
☐ Yes ☐ No

Amount of loss claimed: _____

Please explain the relevant facts regarding your claim: _____

Statement of facts (continued):

Send Completed Form To:

Executive Director
SBAND
P.O. Box 2136
Bismarck, ND 58502-2136