



FLORIDA DENTAL HEALTH FOUNDATION Disaster Fund Application

PERSONAL INFORMATION

Name of Applicant _____ E-mail _____
 Address _____ City, State, ZIP _____
 County _____ Home Phone (_____) _____ Office Phone(_____) _____
 FL Dental License # _____ Dental Laboratory Registration # _____

NATURE OF DISASTER: Provide a description of the nature of the disaster. Attach supporting articles, documents, pictures, etc. Be specific as to time, day, and date in completing this section. *(Continue on back of this form, if necessary).*

AMOUNT OF DAMAGE: Structure \$ _____ Equipment \$ _____ Supplies \$ _____
 Total Damage \$ _____ Insurance Coverage \$ _____ Net Loss After Insurance \$ _____

INSURANCE COMPANY INFORMATION

Name of Company _____ Phone Number (_____) _____
 Address _____ City, State, ZIP _____
 Agent's Name _____ Policy Number _____
 Coverage Amount \$ _____ Deductible Amount \$ _____

FINANCIAL INFORMATION

Name of Bank _____ Phone Number (_____) _____
 Address _____ City, State, ZIP _____
 Checking Account # _____ Savings Account _____
 Money Market Account # _____ Total Assets \$ _____

Have you applied for a loan from a financial institution to help you in your time of emergency? Yes No
 Has the loan been denied? Yes No

IDENTIFICATION OF OTHER SOURCES OF AID

Small Business Administration \$ _____ Family and relatives \$ _____
 Other sources \$ _____ Other \$ _____ Other \$ _____

I hereby certify that the information contained in this document is true and complete. I hereby authorize any corporation, firm, agency or institution to furnish to the Florida Dental Health Foundation Inc. any and all information in its possession relative to my assets, deposits, dealings or business of any kind whatsoever.

 SIGNATURE OF APPLICANT

 DATE

RETURN APPLICATION TO: Florida Dental Health Foundation ■ Disaster Relief Assistance
 1111 E. Tennessee St. ■ Tallahassee, FL 32308 ■ 800-877-9922