DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

HAWAII POST-SECONDARY EDUCATION AUTHORIZATION PROGRAM (HPEAP)

CLAIM FORM AGAINST PRIVATE COLLEGE OR UNIVERSITY

THAT CEASED OPERATIONS

This claim form should only be used to file a claim against a private college or university authorized by the Hawaii Post-Secondary Education Authorization Program (HPEAP).

To file a claim you must be a student or enrollee, or a parent or legal guardian of the student or enrollee, who claims loss of tuition or fees as a result of cessation of operations if the claim results from an act or practice that violates a provision of HRS Chapter 305J. The student must have been enrolled in the private college or university at the time it ceased operations.

Please describe your claim and submit copies of all supporting documentation. You must include 1) all relevant dates including the last day you attended this institution; 2) names and contact information of people you communicated with regarding this claim; 3) names and contact information of any witnesses; and 4) the relief/remedy you are seeking.

Submit your claim to:

Hawaii Post-Secondary Education Authorization Program
Department of Commerce and Consumer Affairs
P.O. Box 541
Honolulu, HI 96809

Name of Claimant: _____

Phone Number: _____ Email Address: _____

Mailing Address: _____

Residence Address: _____

Name of Institution: _____

Institution's Address: _____

CLAIM. Please type or print clearly in black ink your specific claim for loss of tuition or fees against the institution that ceased operations. Attach copies of all pertinent documents (contracts, letters, receipts, promissory notes, financial aid statements, photographs); and the names, addresses, and telephone numbers of any witnesses. If you attach a credit card or bank statement, be sure your account number is removed or obliterated. If you need additional space, continue on a separate sheet of paper and attach to this form.

AFFIDAVIT OF APPLICANT:

By submitting this form, I hereby request and authorize the institution to disclose all records pertaining to me and my claim to HPEAP and its authorized representatives, to investigate my claim under HRS Chapter 305J.

___ I AGREE ___ I DO NOT AGREE

_____ _____

Date Claimant's Signature

I hereby certify that the answers and statements contained in this claim form and the documents attached are true and correct.

___ I AGREE ___ I DO NOT AGREE

_____ _____

Date Claimant's Signature