

PROPERTY/INLAND MARINE LOSS NOTICE

| | | | |
|--|--------------------|-----------------------------|-----------------------------|
| Reporter Information | | | |
| *First Name: | | *Last Name: | |
| Title: | *Phone: | Email: | |
| Insured Information | | | |
| Policy Number: | | Insured Name: | |
| Street Address: | | | |
| City: | State: | ZIP: | |
| Phone: | | Ext: | |
| Insured Contact Name: | | Insured Contact Email: | |
| Insured Contact Phone: | | Ext: | |
| Incident Information | | | |
| *Date of Incident: | *Time of Incident: | <input type="checkbox"/> AM | <input type="checkbox"/> PM |
| Date Insured Notified: | | | |
| Incident Description: | | | |
| *Incident Location Name: | | | |
| Street Address: | | | |
| City: | State: | ZIP: | |
| Property Information | | | |
| Describe Item(s): | | | |
| *Damage Description: | | | |
| Estimated Damage Cost: | | | |
| Product Information (If Applicable) | | | |
| Describe Item(s): | | | |
| Damage Description: | | | |
| Estimated Damage Cost: | | Estimated Value: | |
| Model: | | Style: | |
| Size: | | Supplier/Vendor: | |

| | | | |
|---|--|---|--|
| Business Interruption Information (If Applicable) | | | |
| Begin Date: | | Begin Time: | |
| | | <input type="checkbox"/> AM <input type="checkbox"/> PM | |
| End Date: | | End Time: | |
| | | <input type="checkbox"/> AM <input type="checkbox"/> PM | |
| Estimated Loss: | | | |
| Owner Information | | | |
| Is Insured the Owner of the Property? <input type="checkbox"/> Yes <input type="checkbox"/> No (If NO, please fill out below) | | | |
| First Name: | | Last Name: | |
| Street Address: | | | |
| City: | | State: | |
| | | ZIP: | |
| County: | | Country: | |
| Home Phone: | | Work Phone: | |
| | | Ext: | |
| Responsible Parties | | | |
| Was the damage caused by an individual? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| First Name: | | Last Name: | |
| Street Address: | | | |
| City: | | State: | |
| | | ZIP: | |
| Home Phone: | | Work Phone: | |
| | | Ext: | |
| Gender: | | Relationship to Insured: | |
| Insurance Company: | | Policy Number: | |
| | | Phone: | |
| Witness Information | | | |
| First Name: | | Last Name: | |
| Street Address: | | | |
| City: | | State: | |
| | | ZIP: | |
| Phone Number: | | Email: | |
| Comments/Remarks: | | | |

Once complete, please submit form to the appropriate contact above.

*Indicates a mandatory field that must be completed in order to accept a claim. However, in order to best process your request, please provide as much information as possible.