LOSS REPORT

Claim No.: ______________________________ *Date:* ______________________________________

Person Making Assignment: ______________________

____	____
Claimant	*Insured*
____	____
Address	*Insured*
____	____
City *State* *Zip*	*Address*
____	____
Phone	*City* *State* *Zip*
____	____
Other Claimants	*Phone*
____	____
Other Data	*Other Data*

COVERAGE:

Name of Insurance Company: ____

Policy No.: __________________________ *Eff. Date:* ________________ *Exp. Date:* ________________

Limits: ____________________________________ *Deductible:* ______________________________________

LOSS / ACCIDENT: *Date:* _________________________ *Time:* ___________________________________

Location: *City:* ______________________________ *State:* ______________________________________

Description: ____
____
____
____
____
____
____