



PROPERTY LOSS NOTICE

INSURER CLAIM NUMBER

INSURANCE COMPANY

BROKER REFERENCE NUMBER

CATASTROPHE NUMBER

POLICY NUMBER

1. INSURED'S FULL NAME AND POSTAL ADDRESS**2. BROKER'S NAME AND POSTAL ADDRESS**

CONTACT NUMBER HOME CELL BUSINESS FAX POSTAL CODE

CONTACT NUMBER HOME CELL BUSINESS FAX POSTAL CODE

PREFERRED LANGUAGE ENGLISH FRENCH

BROKER CONTRACT NUMBER BROKER SUB-CONTRACT NUMBER

EMAIL ADDRESS

GROUP / PROGRAM NAME

GROUP ID

WEBSITE ADDRESS

BROKER CLIENT ID

COMPANY CLIENT ID

3. ALTERNATE CONTACT INFORMATION

RELATIONSHIP TO INSURED

CONTACT NUMBER HOME CELL BUSINESS FAX

4. POLICY PERIODEFFECTIVE DATE TIME A.M. P.M. EXPIRY DATE AT 12:01 A.M. ALL TIMES ARE LOCAL TIMES AT THE APPLICANT'S POSTAL ADDRESS STATED HEREIN.**5. RISK ADDRESS** SAME AS SECTION 1

LOCATION OF LOSS

6. COVERAGE INFORMATION PERSONAL COMMERCIAL FARM

PACKAGE FORM AND TYPE

SINGLE LIMIT	DWELLING BUILDING	DETACHED STRUCTURES	PERSONAL PROPERTY	ADDITIONAL LIVING EXPENSES	LEGAL LIABILITY	VOLUNTARY MEDICAL PAYMENT	VOLUNTARY PROPERTY DAMAGE	DEDUCTIBLE \$
\$	\$	\$	\$	\$	\$	\$	\$	\$

7. ADDITIONAL COVERAGE (Specify rating information, limits deductibles, etc.)

CODE	COVERAGE DESCRIPTION	LIMIT #1	DEDUCTIBLE	DED. TYPE	1 ST TYPE OF

8. LIABILITY EXTENSIONS FROM PRIMARY LOCATION

CODE	LIABILITY COVERAGE DESCRIPTION	NUMBER OF	TYPE OF

9. SCHEDULED PERSONAL PROPERTY DETAIL

#	CLASS CODE	DESCRIPTION (INCLUDING SERIAL / IDENTIFICATION NUMBER)	COVERAGE CODE	QUALIFIER 1	QUALIFIER 2	PURCHASE / APPRAISAL DATE	DEDUCTIBLE	DISC. %	AMT OF INS.
1									
2									

10. WATERCRAFT AND TRAILERS (indicate if boat trailer or travel trailer)

#	TYPE	YEAR	LENGTH	DESCRIPTION MAKE/MODEL	COVERAGE	DEDUCTIBLE	AMT OF INS.
1							
2							

11. ADDITIONAL INTERESTS

#	NAME AND ADDRESS	NATURE OF INTEREST
1		
2		
3		

12. DETAILS OF LOSS

RISK NO.	DATE	TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	LOSS TYPE

DETAILS OF LOSS



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13. AUTHORITY REPORT INFORMATION

<input type="checkbox"/> POLICE	<input type="checkbox"/> FIRE DEPARTMENT	<input type="checkbox"/> OTHER
MUNICIPALITY/CITY	MUNICIPALITY/CITY	MUNICIPALITY/CITY
DIVISION NUMBER	STATION NUMBER	LOCATION NUMBER
OFFICER'S NAME	CONTACT NAME	CONTACT NAME
CONTACT NUMBER	CONTACT NUMBER	CONTACT NUMBER
BADGE NUMBER	BADGE NUMBER	BADGE NUMBER
DATE REPORTED	DATE REPORTED	DATE REPORTED
OCCURENCE NUMBER	REPORT NUMBER	REPORT NUMBER
CHARGES LAID	OTHER	CHARGES LAID

14. INJURED PARTY NONE REPORTED Specify Type: A = Insured B = Third party C = Unknown

CONTACT NUMBER HOME	CELL	PREFERRED LANGUAGE	NATURE OF INJURY	POSTAL CODE
BUSINESS	FAX	<input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH		HOSPITALIZED <input type="checkbox"/> YES <input type="checkbox"/> NO

15. REMARKS**16. WITNESS CONTACT INFORMATION**

CONTACT NUMBER HOME	CELL	PREFERRED LANGUAGE	POSTAL CODE
BUSINESS	FAX	<input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH	

17. ADJUSTER ASSIGNMENT INFORMATION

CONTACT NUMBER HOME	CELL	EMAIL ADDRESS
BUSINESS	FAX	
REPORTED BY	DATE	TIME
REPORTED TO COMPANY BY	DATE	TIME
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
		<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.