

**American Bankers Insurance Company of Florida
Reliable Lloyds Insurance Company
Voyager Indemnity Insurance Company**

P.O. Box 977122, Miami, FL 33157 • 1.800.327.5288 • Fax 1.305.252.6910

PROPERTY INSURANCE RETAIL & CONSUMER LOAN PROOF & NOTICE OF LOSS

Fax completed form and any attachments to 1.305.252.6910.

To avoid late fees, continue to make your payments until you receive notification that your claim has been approved.

INSTRUCTIONS

PLEASE NOTE: THIS CLAIM CANNOT BE PROCESSED UNLESS ALL SECTIONS ARE COMPLETE AND THE FOLLOWING INFORMATION IS SUBMITTED.

- A. Have Branch Office Information section completed by your creditor or by the financial institution where the coverage was purchased.
- B. Attach a copy of Certificate of Insurance. (Consumer Loan and Retail Business)**
- C. Attach a copy of the security listing. (Consumer Loan and Retail Business)
- D. Attach a copy of Sales Contract for each item claimed. (Retail Business)
- E. Attach a copy of incident report. (Fire and/or Police Department Report or other document verifying loss.)
If loss is due to burglary, make sure Police Report indicates how entry was gained.
- F. Attach a copy of repair bill or estimate for damaged items.
If repairs have been paid for, please submit a copy of billing showing amount paid.
- G. Be sure to include your Agency Account Number (Item 2 below).

BRANCH OFFICE INFORMATION

1. NAME OF CREDITOR/FINANCIAL INSTITUTION		2. AGENCY ACCOUNT NO. - BRANCH NUMBER			
3. STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER () () () () () ()	FAX NUMBER () () () () () ()
4. TYPE OF BUSINESS <input type="checkbox"/> Consumer Loan <input type="checkbox"/> Sales Finance		5. CERTIFICATE/POLICY/MEMORANDUM NUMBER		6. EFFECTIVE DATE / /	7. EXPIRATION DATE / /
8. AMOUNT OF INSURANCE \$	9. PREMIUM \$	<input type="checkbox"/> Dual Interest <input type="checkbox"/> Single Interest		10. NET INSURED BALANCE AT TIME OF LOSS \$	
11. WAS THIS LOAN REFINANCED <input type="checkbox"/> Yes <input type="checkbox"/> No		12. PREVIOUS LOAN NUMBER		13. PREVIOUS POLICY/CERTIFICATE NUMBER	
NAME OF BRANCH REPRESENTATIVE (PLEASE PRINT)			SIGNATURE OF BRANCH REPRESENTATIVE X		DATE / /

CLAIMANT'S INFORMATION

14. CLAIMANT'S NAME		15. CLAIMANT'S ACCOUNT NUMBER			
16. STREET ADDRESS/APT		CITY	STATE	ZIP CODE	
17. HOME PHONE () ()	BUSINESS PHONE () ()	18. CLAIMANT'S E-MAIL ADDRESS (IF AVAILABLE)			
19. TYPE OF LOSS		20. DATE OF LOSS / /	21. DEGREE OF LOSS <input type="checkbox"/> Total <input type="checkbox"/> Partial		

ITEMS CLAIMED MUST BE LISTED BELOW

Branch Representative - include Dealer Percentage (if applicable).*

ARTICLE	PURCHASE DATE	PURCHASE PRICE	REPAIR COST (if repairable)	D.C. + % + TAX*
	/ /	\$	\$	
	/ /	\$	\$	

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET OR USE A SECOND CLAIM FORM.

TOTAL AMOUNT BEING CLAIMED \$ _____

I AUTHORIZE any insurance or reinsuring company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data, or information concerning this claim to furnish such record, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

CLAIMANT'S NAME (PLEASE PRINT)	CLAIMANT'S SIGNATURE X	SOCIAL SECURITY NUMBER — —	DATE / /
NAME OF CREDITOR REPRESENTATIVE (PLEASE PRINT)	CLAIMANT'S SIGNATURE X		DATE / /

INSURANCE COMPANY USE ONLY

ASSIGNED TO	ADJUSTER	DATE ASSIGNED / /
STREET ADDRESS	CITY	STATE ZIP CODE ()

FL residents only: Pursuant to § 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in § 775.082, § 775.083, or § 775.084, Florida Statutes.

OK residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.