



# CLAIMS HISTORY / LOSS RUN REQUEST

DATE (MM/DD/YYYY)

AGENCY		INSURED'S NAME AND MAILING ADDRESS (Include county & ZIP+4)		TELEPHONE NUMBER
CONTACT NAME:		POLICY #:		
PHONE (A/C. No. Ext):		CARRIER NAME AND ADDRESS		NAIC CODE
FAX (A/C. No.):				
E-MAIL ADDRESS:				
CODE:	SUBCODE:			
AGENCY CUSTOMER ID:				

## CLAIMS HISTORY / LOSS RUN REQUEST

Please be advised that we request and authorize \_\_\_\_\_ years claims history be sent to the insurance agency referenced above.  
 # Years

Check all that apply:	POLICY NUMBER (if different from above)
<input type="checkbox"/> PROPERTY	
<input type="checkbox"/> LIABILITY	
<input type="checkbox"/> AUTO	
<input type="checkbox"/> WORKERS COMPENSATION	
<input type="checkbox"/> UMBRELLA / EXCESS	
<input type="checkbox"/> CRIME	
<input type="checkbox"/> INLAND MARINE	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

\_\_\_\_\_  
 APPLICANT / NAMED INSURED SIGNATURE

\_\_\_\_\_  
 DATE (MM/DD/YYYY)