

**CSIO****PROPERTY LOSS NOTICE**

POLICY NUMBER

REPORT DATE (YYYY/MM/DD)

INSURER				BROKER		CODE	PHONE	CLIENT ID
INSURED				ADDRESS			BUS. #	RES. #
PREVIOUSLY REPORTED	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	IF YES, DATE REPORTED	REPORTED BY	TO	
ADJUSTER ASSIGNED:				ADJUSTER NO.		DATE	PHONE	CATASTROPHE NO.

**1. CONTACTS**

<input type="checkbox"/>	INSURED	NAME	LANGUAGE	BUS. #	RES. #
<input type="checkbox"/>	OTHER	ADDRESS		WHERE TO CONTACT	WHEN
<input type="checkbox"/>	INSURED	NAME	LANGUAGE	BUS. #	RES. #
<input type="checkbox"/>	OTHER	ADDRESS		WHERE TO CONTACT	WHEN
<input type="checkbox"/>	INSURED	NAME	LANGUAGE	BUS. #	RES. #
<input type="checkbox"/>	OTHER	ADDRESS		WHERE TO CONTACT	WHEN

**2. LOSS INFORMATION**

DATE (YYYY/MM/DD)	CAUSE OF LOSS	TYPE OF LOSS	LIABILITY	BUILDING	CONTENTS
TIME <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		ESTIMATED VALUE \$	\$	\$	\$
LOCATION OF LOSS		POLICY LOC.#	POLICE/FIRE DEPARTMENT REPORTED TO		
DESCRIPTION OF LOSS AND DAMAGE		MUNICIPALITY			
		DIVISION NO.			
		OFFICER'S NAME			
		BADGE NO.			
		PHONE			

**3. INJURIES**

NAME AND ADDRESS	LANGUAGE	BUS. #	RES. #
	NATURE OF INJURY		AGE
NAME AND ADDRESS	LANGUAGE	BUS. #	RES. #
	NATURE OF INJURY		AGE

**4. POLICY AND COVERAGE INFORMATION**

PERSONAL: FOR POLICY # SHOWN ABOVE	EFF. DATE	EXP. DATE	FORM / TYPE	DEDUCTIBLE \$			
SINGLE LIMIT	DWELLING BUILDING	DETACHED STRUCTURES	PERSONAL PROPERTY	ADDITIONAL LIVING EXPENSES	LEGAL LIABILITY	VOLUNTARY MEDICAL PAYMENT	VOLUNTARY PROPERTY DAMAGE
\$	\$	\$	\$	\$	\$	\$	\$

DETAILS OF ADDITIONAL COVERAGES, FLOATERS OR EXCLUSIONS AFFECTING THIS LOSS

COMMERCIAL: FOR POLICY # SHOWN ABOVE	EFF. DATE	EXP. DATE	FORM / TYPE	DEDUCTIBLE \$
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DETAILS OF COVERAGES, LIMITS, DEDUCTIBLES AND DESCRIPTIONS OF ITEMS INVOLVED IN THE LOSS

**ADDITIONAL INTERESTS:**

NAME AND ADDRESS	NATURE OF INTEREST	POLICY NO.	EFF. DATE
		INSURER	EXP. DATE
NAME AND ADDRESS	NATURE OF INTEREST	POLICY NO.	EFF. DATE
		INSURER	EXP. DATE
NAME AND ADDRESS	NATURE OF INTEREST	POLICY NO.	EFF. DATE
		INSURER	EXP. DATE

**OTHER INSURANCE:**