

DIVERSIFIED AGRISURANCE COMPANY

for

Acceptance Insurance Company Central States Indemnity Co. Insurance Corporation of Hanover

SWORN STATEMENT IN PROOF OF LOSS

Claims MUST be received within 90 days of the date of loss.

CLAIM NO. _____

POLICY NUMBER _____ EFFECTIVE DATE _____ EXPIRATION DATE _____

NAME OF INSURED _____

PROPERTY DAMAGED: SERIAL NUMBER _____ MAKE _____ MODEL _____

LOCATION OF LOSS: _____

CAUSE OF LOSS & DAMAGE: _____

Date of loss: _____ County: _____ State: _____ Time of loss: _____ A.M. _____ P.M.

Other insurance? Yes No. If yes, name of company _____

Mortgagee or lienholder _____

THE AMOUNT OF COVERAGE on the insured property at the time of loss \$ _____

TOTAL ESTIMATED REPAIR COST to the described property at time of loss was \$ _____

LESS AMOUNT OF DEDUCTIBLE..... \$ _____

AMOUNT CLAIMED \$ _____

Please Note: no payment will be made based on an estimate. Payment will be made only after the final bill has been received and unit has been repaired.

I hereby attest that the above information is true and accurate to the best of my knowledge.