

# GERMANIA MUTUAL INSURANCE COMPANY PRELIMINARY CLAIMS REPORT

**Date:** \_\_\_\_\_ **To:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_  
Adjusting Company (Head Office Use Only)

**Attention:** \_\_\_\_\_ **Number of Pages to Follow This Sheet:** \_\_\_\_\_  
Adjuster's Name (Head Office Use Only)

**Broker:** \_\_\_\_\_ **Broker Phone #** \_\_\_\_\_  
Insurance Company

**Loss Date:** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Policy Dates:** \_\_\_\_\_  
Day/Mo/Yr Effective - Expiry (Day/Mo/Yr)

**Insured's Name:** \_\_\_\_\_

**Insured's Address:** \_\_\_\_\_

**Insured's Phone Number:** \_\_\_\_\_  
Res: Bus: Other:

**Location of Loss:** \_\_\_\_\_

**Cause of Loss:** \_\_\_\_\_

Coverage Section				
Section #	Item #	Amount of Insurance	Deduct	Description of Coverage

**DETAILS OF LOSS - (Include Insured's Description of Loss & Estimate of Damage)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ **Date** \_\_\_\_\_ **Broker's Signature** Revised: Sept. 16, 2002