



P.O. Box 7001 – Crossville, TN 38557- 1-800-752-8328
 Email: propertyclaims@plateaugroup.com

PROPERTY LOSS
 INSURANCE CLAIM FORM

CLAIM DEPT. USE ONLY	
Claim Number	_____
Date Received	_____
Setup	By _____
Adjusted	By _____
Amount	_____
Dates	_____
Remarks	_____

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

- A. COPY OF CERTIFICATE OF INSURANCE (Consumer Loan and Retail Business).
- B. COPY OF THE SECURITY LISTING AND PAYMENT HISTORY (Consumer Loan and Retail Business).
- C. COPY OF SALES CONTRACT FOR EACH ITEM CLAIMED (Retail Business).
- D. COPY OF INCIDENT REPORT (Fire and/or Police Department Report or other document verifying loss on all claims).

CREDITOR INFORMATION

NAME		PRODUCER NUMBER	
STREET ADDRESS		CITY	STATE ZIP
MANAGER'S NAME		CREDITOR'S PHONE NUMBER ()	
SIGNATURE X		DATE	

CLAIMANT INFORMATION

NAME		SOCIAL SECURITY UMBER
STREET ADDRESS		
CITY/STATE/ZIP		
HOME PHONE	BUSINESS PHONE	DATE

INSURANCE INFORMATION

CERTIFICATE/POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	TERM
AMOUNT OF INSURANCE \$ _____	PREMIUM \$ _____	<input type="checkbox"/> DUAL INTEREST <input type="checkbox"/> SINGLE INTEREST	NET INSURED BALANCE AT TIME OF LOSS \$ _____
MONTHLY PAYMENT AMOUNT \$ _____	PAYMENT DUE DATE	CURRENT/PRIOR CLAIM NUMBER	TYPE OF LOSS
DATE OF LOSS	DEGREE OF LOSS (Partial or Total)	IF RENEWAL, EARLIEST DATE OF CONTINUOUS COVERAGE	
LOSS PAYABLE TO (Name & Full Address)			

FOR YOUR PROTECTION, THE FOLLOWING IS REQUIRED TO APPEAR ON THIS FORM: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, and may be subject to fines and confinement in state prison.

PLEASE COMPLETE BACK PAGE



ITEMS CLAIMED MUST BE LISTED BELOW:

ARTICLE	PURCHASE DATE	PURCHASE PRICE	REPAIR COST (If Repairable)	ACTUAL CASH VALUE AT TIME OF LOSS
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
	/ /	\$	\$	\$
IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET OR USE A SECOND CLAIM FORM.		TOTAL AMOUNT CLAIMED \$ _____		

THE FURNISHING of this form or the preparation of proofs by a representative of the above insurance company is not a waiver of any of its rights. The said loss did not originate by an act, design or procurement on the part of your insured, or its affiant; nothing has been done by our with the privity or consent of your insured or this affiant, to violate the conditions of the policy, or render if void; no articles are mentioned herein or in annexed schedules but such as were destroyed or damaged at the time of said loss, no property saved has in any manner been concealed, and no attempt to deceive the said company, as to the extent of said loss, has in any manner been made. Any other information that may be required will be furnished and considered a part of this proof.

Signature of Insured	Date
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I HEREBY certify that the loss has been carefully investigated, that it occurred as stated and, in my opinion, is in order for payment.

Completed By (Print)	
Signature	Date

