SCU
A CRC GROUP COMPANY

AGENCY: _____
_____
_____

LOSS REQUEST FORM

Named Insured*: _____
Insured Contact*: _____
Primary Phone*: _____
Secondary Phone*: _____
E-mail Address*: _____

Policy Number: _____
Policy Effective Date: _____
Date of Loss*: _____

Location Where Loss Occurred
Street Address*: _____
City*: _____ State*:_____

Short description
of incident*: _____

Description of
property damage*: _____

Names of injured
person(s) (if any): _____

Vehicle(s) involved: _____

Person Reporting Claim
Name*: _____
Primary Phone*: _____
Secondary Phone*: _____
E-mail Address*: _____

***Indicates required fields**

Print Email