



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**