BUSINESS INCOME CLAIM FORM

(PLEASE FILL OUT)

Insured's Name: ______________________________

Insurance Company: ______________________ Policy Number: ______________

Insured's Address: ______________________________

Date Business Income Loss Began: ______________________________

Description of Loss: ______________________________

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Estimated Loss Amount, if known: $ ______________________________

Other Important Details: ______________________________

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Reported by: ______________ Phone: ______________ Date: ______________

Signature: ______________________________

Email copy of this report to:
claimsreport@sullicurt.com
If you have any questions after submission of claim form, please call (800) 427-3253.
Please confirm when you receive confirmation of your claim and adjuster assignment from your carrier.

SullivanCurtisMonroe Insurance Services, LLC
1920 Main Street, Ste. 600 | Irvine, CA 92630 | CA Insurance License 0E83670