



SCHEDULE OF LOSS

Page _____ of _____

Please complete and return to: _____

Insured: _____ Policy No.: _____ Date of Loss: _____ Claim No.: _____

To be Completed by the Insured						Office Use Only			
No	Item (Make, Model, Size, etc.)	Where Purchased	Approx. Date Purchased	Approx. Purchase Price	Approx. Replacement Cost	Depreciation	ACV for Cash Settlement	Actual Replacement Cost	Amount Claimed Balance
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									

Date: _____ Signature of Insured: _____

**Making false, misleading or exaggerated statements is in violation of the Conditions of the Insurance Policy and will lead to denial of the claim.*