



# STATEMENT OF NO LOSS

|                       |          |               |           |
|-----------------------|----------|---------------|-----------|
| AGENCY                |          | NAMED INSURED |           |
| CONTACT NAME:         |          | CARRIER       | NAIC CODE |
| PHONE (A/C, No, Ext): |          |               |           |
| FAX (A/C, No):        |          | POLICY NUMBER |           |
| E-MAIL ADDRESS:       |          | APPROVED BY   |           |
| CODE:                 | SUBCODE: |               |           |
| AGENCY CUSTOMER ID:   |          |               |           |

I CERTIFY THAT I AM NOT AWARE OF ANY LOSSES, ACCIDENTS OR CIRCUMSTANCES THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE NUMBER IS SHOWN ABOVE, FROM 12:01 AM ON \_\_\_\_\_ TO \_\_\_\_\_ .

CANCELLATION DATE

DATE AND TIME SIGNED

\_\_\_\_\_  
APPLICANT'S SIGNATURE

## RECEIPT

\$ \_\_\_\_\_ AMOUNT RECEIVED BY: \_\_\_\_\_

PRODUCER

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE AND TIME