Verification of Loss History

Applicant Name: _____

Federal Employer Tax ID Number or Social Security Number: _____

☐ **We verify that the applicant named above has had no employee occupational losses in the previous three (3) years.**

☐ **We verify that the previous three (3) years loss information for the above named applicant, as submitted below, is true and accurate.**

Please include all losses that occurred in the previous three (3) years.

Date	Nature of Injury	Total Paid	Reserved/ Outstanding	Claim Status

*** This form is part of the application for insurance and the application becomes part of the policy. We, the undersigned, agree that the statements made herein are our representations, that the policy is issued in reliance upon such representations and, all coverage afforded in the policy is fully conditional upon these true and factual statements.**

We attest to these statements and representations:

Authorized Signature of Applicant: _____

Title: _____ **Date:**_____

Signature of Licensed Recording Agent: _____

Agency Name: _____ **Date:**_____