Schedule of Loss

Please complete and return this form to:

Name of Insured	Policy No.	Date of Loss	File No.	Page ____ of ____ pages

TO BE COMPLETED BY THE INSURED							TO BE COMPLETED BY THE ADJUSTER				
NO.	1 QTY	2 ITEM DESCRIPTION (Make, Model, Size, Serial No. etc.)	3 PURCHASED FROM (Supplier Name and Location)	4 APPROX DATE PURCHASED	5 APPROX PURCHASE PRICE	6 REPLACEMENT OR REPAIR COST	7 DEPRECIATION	8 ACTUAL CASH VALUE	9 ACTUAL REPLAC. COST (REPLACED)	10 SALVAGE VALUE	11 AMOUNT CLAIMED BALANCE
				TOTALS							

I/we confirm that the above list is exact and complete

Insured _____ Insured _____

Date _____ Date _____