_	FORM TITLE FORM #								PAGE	
<u></u>		CLAIM F	M REPORTING FORM					CL-02 (1/06) 1 OF		
		Today's Date:				Policy#:				
	Ina.wanaa Daaree T	1	Type of Loss: Pho					ne#:		
	Insurance Reserve Fu Claims Department	ınd	Insur	ed (Entity):	(Entity):					
	Claims Department P.O. Box # 11066		Addr							
	Columbia, SC 29211 (803) 737-0020									
	(803) 737-0020									
	ENTITY CONTACT FOR CLAIM:									
CT	PHONE NUMBER	SION EMAIL ADDRESS								
CONTACT	EATENOI									
8	BEST TIME TO REACH									
	DATE & TIME OF LOSS A.M. CAUSE OF CLAIM:					ESTIMATED AMOUNT OF LOSS (\$):				
	P.M. DESCRIPTION OF LOSS (Use reverse, if necessary)									
	` ' "									
SSOT										
	PROPERTY DAMAGED				PROPERTY VALUES (\$)					
DAMAGE	SEGMENT#/BUILDING	BUILDING NAME			BUILDIN	G	CC	CONTENTS		
PROPERTY										
PR										
TS	INVOICES ATTACHED:	YES N	NO PAC	GE QTY	Р	HOTOS ATTACHED:	YES	NO PAGE QT	Y	
ATTACHMENTS	POLICE DEPARTMENT REPORT ATTACHED:	YES N	NO PAC	GE QTY	R	FIRE DEPARTMENT EPORT ATTACHED: :	YES	NO PAGE QTY	,	
ATT/	PREPARED BY:									