

REQUEST FOR REIMBURSEMENT - AGGREGATE CLAIM

Insured: _____
Policy No.: _____ Policy Dates: _____

Loss Fund at: _____ %	\$ _____
Minimum Term Loss Fund (MTLF)	\$ _____
Total Claims Paid Through _____	\$ _____
Less Claims Applicable to Specific	\$ _____
Total Claims Applicable to Loss Fund	\$ _____
Less Assessments, SDF or other... (Specific)	\$ _____
Less Greater of Loss Fund or MTLF	\$ _____
Aggregate Claim	\$ _____
Less Previous Reimbursements	\$ _____
Balance owed a/o _____	\$ _____

Loss run summary must be attached to process reimbursement

Total Number of Open Claims _____
Less Claims Closed This Period _____
Net Open Claims _____

SWORN STATEMENT IN PROOF OF LOSS

The undersigned, as the designated representative for the above Named Insured, states that the above figures are true and correct. Any statements attached hereto are made part of this instrument.

By: _____ Date: _____

PLEASE PRINT OR TYPE: **This form completed as of** _____
Name: _____
Company: _____
Address: _____
City/State/Zip: _____
Phone Number: _____

Safety National Casualty Corporation
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