



STATEMENT OF NO LOSSES		
PROGRAM ADMINISTRATOR: PRODUCER CODE: FIRST NAMED INSURED:	ACCOUNT NUMBER: 	
	POLICY NUMBER:	EFFECTIVE DATE:
<p>I CERTIFY THAT THERE HAVE BEEN NO LOSSES, ACCIDENTS OR CIRCUMSTANCES THAT MIGHT GIVE RISE TO A CLAIM UNDER THE INSURANCE POLICY WHOSE NUMBER IS SHOWN ABOVE,</p> <p>FROM 12:01 A.M ON _____ TO _____ (POLICY EFFECTIVE DATE OR POLICY CANCELLATION DATE AS APPLICABLE) DATE AND TIME SIGNED</p> <p style="text-align: center; margin-top: 20px;"> _____ INSURED'S SIGNATURE (signature required) </p> <p style="text-align: center; margin-top: 20px;"> _____ PRINT INSURED'S NAME AND TITLE </p> <p style="margin-top: 20px;"> _____ _____ WITNESS DATE AND TIME (signature required) </p>		

Please complete **all** lines including the witness signature, date and time. The no loss letter will be considered VOID if any lines have not been completed.