

LOSS REPORT
 Texas Insurance Checking Office, Inc.

F & R

Co. Name _____

Acc. Date _____

	1	2			3	4	5	6	7
		Date of Loss							
	Policy Number	Month	Day	Year	Trans. Kind	Cause of Loss	Claim Count	Amt. Of Insurance or Exposure	Amount Paid or Reserved
1									
2									
3									
4									
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