American Bankers Insurance Company of Florida
Reliable Lloyds Insurance Company
P.O. Box 977122, Miami, FL 33197-7122 • 1.800.327.5288 • Fax 305.252.6910
Attn: DFS Claims Department

MUSICAL INSTRUMENT INSURANCE POLICY PROOF OF LOSS FORM

IMPORTANT NOTICE
PLEASE READ CAREFULLY BEFORE COMPLETING YOUR CLAIM FORM

Failure to complete required sections and/or provide requested documentation will delay processing of your claim.

INSTRUCTIONS FOR COMPLETING FORM

If the needed sections are not complete or if the attachments are not attached, the processing of the claim will be delayed. (Check box after each item is completed.)

- ☐ **1. Complete Section 1.**
- ☐ **2. If payment is to be made to anyone other than the insured, complete Section 2.**
- ☐ 3. **If damaged,** submit estimate or paid bill for repair. If you have paid for repair, reimursement will be made directly to insured as indicated on insurance Policy.
- ☐ 4. **If Stolen**, you must attach a copy of the police report.
- ☐ **5. Attach a copy of policy**
- ☐ 6. Attach a copy of the rental or lease contract (if applicable).

Fax completed form and all supporting documentation to 305.252.6910 or mail to:

DFS Claims Department
PO Box 977122
Miami FL 33197-7122

ONCE YOUR CLAIM IS RECEIVED

- **YOU WILL RECEIVE A LETTER ACKNOWLEDGING RECEIPT OF YOUR CLAIM. THE LETTER WILL CONTAIN YOUR CLAIM NUMBER.**
- **PLEASE ALLOW 15 BUSINESS DAYS FOR YOUR CLAIM TO BE PROCESSED.**
- **AFTER YOUR CLAIM HAS BEEN PROCESSED, YOU WILL RECEIVE A LETTER ADVISING OF APPROVAL, DENIAL OR REQUEST FOR ADDITIONAL INFORMATION.**

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MUSICAL INSTRUMENT INSURANCE POLICY

SECTION 1. DEALER/SCHOOL INFORMATION			CLAIMANT'S INFORMATION		
1. NAME OF STORE OR SCHOOL			7. NAME OF CLAIMANT/ INSURED		
2. STREET ADDRESS			8. STREET ADDRESS, APT. #		
3. CITY	STATE	ZIP CODE	9. CITY	STATE	ZIP CODE
4. CONTACT PERSON			10. HOME TELEPHONE NUMBER ( )	DAY TELEPHONE NUMBER ( )	
5. TELEPHONE NUMBER ( )	FAX NUMBER ( )		11. CLAIMANT'S E-MAIL ADDRESS (IF AVAILABLE)		
6. TYPE OF LOSS			12. DATE OF LOSS / /	13. DEGREE OF LOSS ☐ Total ☐ Partial	
14. DESCRIPTION OF LOSS OR DAMAGE					

ITEMS CLAIMED MUST BE LISTED BELOW.

15. INSTRUMENT INFORMATION	MODEL NUMBER	16. REPLACEMENT VALUE OR	17. REPAIR COST
		$	$
		$	$
		$	$

Claim for loss or damage may be subject to a $15.00 deductible.

TOTAL AMOUNT BEING CLAIMED $_____

I AUTHORIZE any insurance or reinsuring company, insurer, law enforcement agency, fire department, or other organization, or person having any records, data, or information concerning this claim to furnish such record, data, or information to the insurance company issuing my policy. I understand that in executing this authorization, I waive the right for such information to be privileged as it pertains to the processing or investigation of my claim(s). A photocopy of this authorization shall be considered as effective and valid as the original.

I, or my authorized representative, have the right to receive a copy of this authorization.

This authorization shall remain valid for the duration of the claim.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals, for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and substantial civil penalties. **For other Fraud Statements see Page 3.**

SIGNATURE OF PERSON COMPLETING FORM	DATE
X	/ /

(Complete this portion only if payment is to be made to someone other than insured.)

SECTION 2. AUTHORIZATION TO PAY

I authorize payment of $_____, to:

NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE

INSURED'S SIGNATURE	DATE
X	/ /

CO residents only: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

MD residents only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ residents only: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TX residents only: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

WA residents only: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.