CO-OPERATIVE HAIL INSURANCE COMPANY LIMITED

POLICY NUMBER _____

NOTICE OF LOSS

HEAD OFFICE AT
2709 - 13TH AVENUE
REGINA, SASKATCHEWAN
S4T 1N4

since 1917 co-op Hail

ISSUED FOR ☐ SASKATCHEWAN ☐ MANITOBA

EFFECTIVE DATE	D	M	Y	D	M	Y
				31	10	

I SUSTAINED A LOSS TO MY CROP BY HAIL, INSURED UNDER THE ABOVE POLICY, WHICH OCCURRED

ON THE _____ DAY OF _____ 20_____, AT ABOUT THE HOUR OF _____ ☐ A.M. ☐ P.M.

THE TOWN OR VILLAGE NEAREST THE LOSS IS _____ I RESIDE ON THE

_____ QUARTER OF SEC. _____ TWP. _____ RGE. _____ MER. _____ MILES _____ OF SAID STATION. PHONE _____

MY POST OFFICE ADDRESS IS _____ CELL _____

INSURED'S FULL NAME _____

ADDRESS _____

_____
POSTAL CODE

IMPORTANT

FAX: (306) 352-9130

☐ **NOTICE OF LOSS WAS FAXED**

PHONE NO. _____

CELL NO. _____

TYPE OF COVERAGE ☐ FULL COVERAGE ☐ 10% DED ☐ 25% DED

APPLICANT RESIDES ON _____ ¼ OF SEC _____ TP _____ RGE _____ W _____

I AM AWARE THAT THE COMPANY IS LIABLE FOR THE FULL AMOUNT OF LOSS PROVIDED THE LOSS IS 5% OR MORE IN THE CASE OF NON-DEDUCTIBLE POLICY, AND, IN THE CASE OF A DEDUCTIBLE POLICY, TO LOSS IN EXCESS OF SUCH PERCENTAGE AS MAY BE ENDORSED ON THE POLICY IN ACCORDANCE WITH MY APPLICATION FOR INSURANCE. IN THE EVENT THAT THE PERCENTAGE DOES NOT EXCEED THE PERCENTAGE OF EXEMPTION ALLOWED IN MY POLICY, THEN I AGREE TO PAY ON DEMAND THE EXPENSES OF AN INVESTIGATION TO DETERMINE SAME.

ALL OTHER HAIL INSURANCE ON SAME GRAIN MUST BE LISTED TO COMPLY WITH GOVERNMENT REGULATIONS.

THE LOSS IS ON THE FOLLOWING GRAIN:

ITEM NO.	NO. OF ACRES	KIND OF GRAIN	LOCATION PART	SEC.	TP	RANGE	MERID	STAGE OF GROWTH	# OF DAYS FLOWERING	PERCENT OF DAMAGE LIGHT / MEDIUM / HEAVY

IMPORTANT: PLEASE COMPLETE THE LOWER PORTION

POWER OF ATTORNEY

IN THE EVENT OF MY ABSENCE WHEN YOUR ADJUSTER CALLS TO MAKE AN APPRAISAL OF THIS CLAIM, I HEREBY APPOINT _____ WHO RESIDES AT _____ QUARTER OF SEC. _____, TWP. _____, RGE. _____, TO ACT FOR ME AND ON MY BEHALF IN THE ADJUSTMENT OF THE SAID LOSS, AND IN THAT CAPACITY TO MAKE PROOF OF LOSS AND TO DO ALL THINGS REQUIRED BY ME TO BE DONE, PURSUANT TO THE STATUTORY CONDITIONS OF THE SAID POLICY, AND I HEREBY RATIFY ALL THAT MY SAID ATTORNEY MAY DO IN CONNECTION WITH SUCH APPRAISAL AND ADJUSTMENT.

PHONE _____ CELL _____

MY APPLICATION FOR INSURANCE WAS GIVEN TO: _____

AGENT AT _____

DATE WRITTEN: _____ **20** ____

THIS NOTICE OF LOSS MUST BE SIGNED BY THE INSURED, AND MAILED OR FAXED WITHIN 3 DAYS AFTER DAMAGE TO THE CROP

ADVICE TO LOCAL AGENT IS NOT SUFFICIENT
SEND THIS NOTICE TO THE HEAD OFFICE AT THE ADDRESS SHOWN

_____ WITNESS

_____ (SEAL)
(SIGNATURE OF POLICYHOLDER)

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