

SERVICE COMPANY VERIFICATION FORM

Insured

Name: _____

Policy Number: _____

Effective Dates: ____/____/____ Through ____/____/____

Name of Contact: _____

Phone Number: _____ E-mail address: _____

Service Company / Claims Administrator

Name: _____

Contact Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

E-mail address: _____

Broker

Current Agent / Broker: _____

Address: _____

Contact Name: _____ Phone Number: _____

E-mail address: _____

Please Complete and Return

Washington Fraud Warning: "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."

