PRELIMINARY LOSS REPORT FORM
AGENTS OF PROTECTIVE LIFE ERRORS AND OMISSIONS PROGRAM

Please read and complete:

1. Your Name:
2. Your Address:
   Street:
   City: State: Zipcode:
3. Phone #:
4. Policy #:
5. Customer #:
6. Name and Address of Claimant:
   Name:
   Street:
   City: State: Zipcode:
7. Name and Address of Claimant's Attorney:
   Name:
   Street:
   City: State: Zipcode:
8. Person Alleged to Have Committed the Error:
9. Position of Person in Firm:
10. Date of First Awareness of Possible Claim:
11. By What Means:
12. Date of Claim Actually Made :
13. By What Means:
14. Describe Nature of Claim Which May be or is Being Made:

15. Describe Nature and Dollar Amount of Probable Damages:

Firm Name (if applicable) :
By: Date Signed:
Title:

For Expediting Return to:

Zurich America Insurance Company
Post Office Box 968041
Schaumburg, IL 60196-8041
Fax: 866/255-2962
Email: USZ_CareCenter@Zurichna.com