

**COMMERCE PROTECTIVE INSURANCE COMPANY
LOSS RUN REQUEST FORM**

POLICYHOLDER NAME: _____

CONTACT NUMBER: _____

EMAIL: _____

POLICY NUMBER (S): _____

POLICY YEAR(S) REQUESTED FOR LOSS RUN:

NAME AND **SIGNATURE** OF AUTHORIZED PARTY REQUESTING LOSS RUNS:

Name: _____

Signature: _____

INDICATE FAX NUMBER OR EMAIL ADDRESS FOR LOSS RUN DISTRIBUTION:

PLEASE COMPLETE THE REQUEST AND **FAX WITH SIGNATURE** TO THE CLAIMS FAX LINE 717-367-0161