

PREMIER INSURANCE GROUP

Excellence in Coverage • Trusted Since 1985



TXN99900008

24/7 Helpline: 1-800-555-CLAIM | claims@premierinsurance.com

MOBILE DEVICE INSURANCE CLAIM

Claim Date: January 15, 2025

■ TRANSACTION INFORMATION

Transaction ID	Transaction Date	Agent ID
TXN99900008	January 23, 2025 at 10:00 AM	AGENT00450

Vendor ID	Policy Effective Date
VNDR00437	June 01, 2023

■ POLICYHOLDER COMPLETE INFORMATION

Policy Number	Customer ID	Insurance Type
PLC99900008	A99900008	Mobile

Customer Name

Jennifer White

Address Line 1	Address Line 2
135 Fir St	N/A

City	State	Postal Code
Portland	OR	97201

SSN	Age	Marital	Tenure	Education
333-44-5555	29	S	4 months	Bachelor

Employed	Family Members	House Type	Social Class
Employed	1	Rent	Middle

■ COMPLETE INCIDENT DETAILS

Loss Date	Report Date	Hour of Day
January 15, 2025	January 16, 2025	14:00

Incident City	Incident State	Severity
Portland	OR	Minor

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Authority Contacted	Any Injury	Police Report
N/A	No	No

■ FINANCIAL & RISK INFORMATION

Premium Amount	Claim Amount	Claim Status
\$12.00	\$600.00	Pending

Routing Number	Account (Masked)	Risk Segment
555666777	*****9000	Medium

Financial Summary:

- Total Claim Amount: \$600.00
- Monthly Premium: \$12.00
- Risk Category: Medium
- Status: Pending

■ MOBILE DEVICE INSURANCE CLAIM DETAILS

Device Model	IMEI Number
Samsung S23	IMEI999888777666

Loss Type	Proof of Purchase
Theft	Receipt

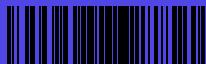
Required Documents for Mobile Device Claim:

- Original Purchase Receipt/Invoice
- Device Photos (if damaged)
- IMEI Screenshot from device settings
- Police Report (if stolen)
- Warranty Card
- SIM Card details
- Device Box with IMEI sticker
- Service center report (if applicable)

■ DECLARATION & AUTHORIZATION

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DECLARATION:

I hereby declare that all the information provided in this claim form is true, complete, and accurate to the best of my knowledge and belief. I have not withheld any material information that may influence the assessment or settlement of this claim.

AUTHORIZATION:

I authorize Premier Insurance Group and its representatives to investigate this claim, including obtaining information from medical providers, employers, government agencies, and any other relevant parties. I understand that any false statement or misrepresentation may result in denial of the claim and may subject me to legal action.

ACKNOWLEDGMENT:

I acknowledge that the settlement of this claim is subject to the terms, conditions, and exclusions of my insurance policy.

Policyholder Signature

Date

Witness Signature

Date