



DEPARTMENT OF FINANCIAL SERVICES

Division of Risk Management

STATE RISK MANAGEMENT TRUST FUND CERTIFICATE OF PROOF OF LOSS

DRM CLAIM NUMBER:		RISK MGMT ADJUSTER:	
DRM LOCATION CODE:		COVERAGE TERM:	
INSURED VALUE/BLDG.:		INSURED VALUE/CONTENTS:	

TO THE STATE RISK MANAGEMENT TRUST FUND OF THE DEPARTMENT OF FINANCIAL SERVICES; BY THE ABOVE INDICATED CERTIFICATE OF INSURANCE YOU INSURED THE FOLLOWING AGENCY, DIVISION, OR UNIVERSITY:

IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE CURRENT STATE RISK MANAGEMENT TRUST FUND CERTIFICATE AND SECTION 284.01, FLORIDA STATUTES.

DATE OF LOSS:		CAUSE:	
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STREET ADDRESS OF THE STRUCTURE SUSTAINING SAID LOSS:	
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AND THE TITLE AND INTEREST OF WHICH ARE IN THE NAME OF **THE STATE OF FLORIDA**.

THE TOTAL AMOUNT CLAIMED UNDER THE ABOVE NUMBERED CERTIFICATE:	Building: \$ Contents: \$ Total: \$
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Notes:

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The said loss did not originate by any act, design, or procurement on the part of your insured. Nothing has been done by or with the privity or consent of your insured to violate the conditions of the policy or render it void. No articles are mentioned herein or in annexed schedules but such as were in the building damaged or destroyed, and belonging to, and in possession of the said insured at the time of said loss. No property saved has in any manner been concealed and no attempt to deceive the said Fund as to the extent of said loss has in any manner been made. Any other information that may be required will be furnished and considered a part of this Proof.

In consideration of and to the extent of said payment, the insured agency hereby subrogates the State Risk Management Trust Fund to all rights, claims, and interest which the insured agency may have against any person or corporation liable for the loss mentioned above, and authorizes the State Risk Management Trust Fund to sue, compromise, or settle in the insured agency's name.

The furnishing of this blank or the preparation of proofs by a representative of the State Risk Management Trust Fund is not a waiver of any of its rights.

CERTIFICATE OF PROOF OF LOSS

I hereby certify that all statements made on this proof of loss are true, and that I have read, understand, and agree with the terms and conditions of coverage on this Proof of Loss. I further certify that the agency assumes sole responsibility in the timely repair or replacement of the losses identified in the Claim Summary which is incorporated by reference in this certificate.

State of Florida, County of: _____

Insured Signature: _____ Date: _____

Title: _____

Witnessed by: _____ Date: _____

SPECIAL INSTRUCTIONS: In order to receive payment, the following section must be completed in its entirety by all State agencies (i.e., all three codes are required). For assistance in locating the correct FLAIR codes, please contact your agency's accounting department. Colleges and Universities are exempt from this requirement.

21-Digit FLAIR Account Code:

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6-Digit Benefiting Object Code:

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6-Digit Benefiting Category Code:

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FCO YR (if applicable):

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