NOTE TO INSURER: This form must be compared with the required contents of the Fire Proof of Loss set out in the Insurance Act of each Province and Territory, and changes must be incorporated as required to ensure full statutory compliance.

required, and withou	OF OF LOSS TH ut prejudice to the liabili	ty of the Insurer	. , ,		OL AIRE NO	
INSURER						
INSURED						
	NAME			ADDRESS		
Under Policy No	ge by	In force	e until amount of			dollare
	s and conditions printed the					uoliais
	A loss occurred on the					A/PM, caused by
	d loss occurred atbuilding insured or contain					
	ST: At the time of the lo			y described was sole and	d unconditional ownership	and no other person or
	ne above policy was issue					
HARMONIZED SALE	ES TAX: The amount clai	med should be net of	recoverable HST			
Is the Insured register					NO	
If the answer is YES,	please state: a) Registra				e	
	OSS: A particular accou					perty insured, the actua
amount of loss or dan	nage, the total insurance	thereon at the time of	the said loss and the	amount claimed under this	s policy are as follows:	
Item Involved	Replacement Cost	Cash Value	Total loss or damage	Total insurance	Amount named this policy	Claimed under this policy
TOTALS						
OTHER INSURANCE	: There is no other contr	act of insurance writte	en or oral, valid or inval	id. except (insurers and a	mounts).	
			,	,		
Payment of this claim						
	and in consideration of su					
recovery from any oth	her person are hereby tra Ilvage is hereby assigned	insferred to the Insure				
1.We						
do solemnly declare declaration conscient	that the foregoing claim iously believing it to be truther solemnly declare that	and statements are ue and knowing that it	to the best of my kr is of the same force a	owledge and belief true nd effect as if made unde	in every particular, and	I/We make this solemn
•	y before me at					
this	day of		20			Insured
Commissioner for Oa	ths or Affidavits			,	nization and Title of Personamed Insured is	· ·

SCHEDULE OF LOSS

Description of Property (make,model,serial #,quantity)	When and where purchased (supplier name & location)	Approx. Date Purchased	Approx. Original cost (purchase price)	Replacement or repair cost	Depreciation	Amount claimed
TOTALS						0
DEDUCTIBLE						
NET CLAIM						

NET CLAIM	<u> </u>					
I/We confirm that the above list is exact and complete:			(Insured)		(Insured)	
			Date		Date	
APPORTIONMENT OF LOSS						·
INSURE	R			POLICY NO.	INSURES	PAYS
				1		
				1		
				1 I		
TOTALS						