



Notice of Damage or Loss

Insurance Provider	Insured	Policy #: Claim #:	Agency	Agent Code:
ARMtech Insurance Services 5102 29th Drive, Suite B. Lubbock, TX 79407	Name: _____ Address: _____ _____		Agency Name: _____ Agent Name: _____ Address: _____	
U/W: (800) 335-0120 Bus.: (806) 473-0333 Claims: (800) 335-6010 (806) 473-0334	Phone: _____		Phone: _____	
Email: ARMtech@arnt.com	Email: _____		Email: _____	

Adjuster:		Claim Type:				
Crop Year	County	Name of Crop	Units	Cause of Damage	Date of Damage	Date Opened

<p><u>I am an agency owner, agent, loss adjuster, FCIC employee, insurance provider employee, or contractor directly associated with the Federal crop insurance program:</u></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Check One:</p> <p><input type="checkbox"/> This is a notice of damage only</p> <p><input type="checkbox"/> This is a notice of probable loss</p> <p><input type="checkbox"/> Immediate inspection is requested. (explain in remarks)</p>	<p>Insured's Intention:</p> <p><input type="checkbox"/> To Harvest <input type="checkbox"/> Replant <input type="checkbox"/> Hay</p> <p><input type="checkbox"/> To Chop/Silage <input type="checkbox"/> Destroy <input type="checkbox"/> Crop will be direct marketed</p> <p><input type="checkbox"/> Leave for Cover <input type="checkbox"/> Pasture <input type="checkbox"/> Other (explain in remarks)</p>
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Remarks

SBI Name	Tax ID	Policy Number (if known)
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If you have less than 100% share, is the other share insured under an MPCl program? If so, list the person's name, name of insurance company for which they carry MPCl insurance and policy number if known.

Person's Name	Name of Insurance Company	Policy Number (if known)
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(Insured Signature)

(Date)

Spouse Name

Spouse Tax ID

NOTE: Refer to the Basic Provisions and the specific Crop Provisions for more details on notice of damage or loss requirements.

COLLECTION OF INFORMATION AND DATA (PRIVACY ACT)

To the extent that the information requested herein relates to your individual capacity as opposed to your business capacity, the following statements are made in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a). The authority for requesting information to be furnished on this form is the Federal Crop Insurance Act (7 U.S.C. 1501 et seq.) and the Federal crop insurance regulations contained in 7 C.F.R. chapter IV.

Collection of the social security account number (SSN) or the employer identification number (EIN) is authorized by section 506 of the Federal Crop Insurance Act (7 U.S.C. 1506), and is required as a condition of eligibility for participation in the Federal crop insurance program. The primary use of the SSN or EIN is to correctly identify you, and any other person with an interest in you or your entity of 10 percent or more, as a policyholder within the systems maintained by the Federal Crop Insurance Corporation (FCIC). Furnishing the SSN or EIN is voluntary; however, failure to furnish that number will result in denial of program participation and benefits.

The balance of the information requested is necessary for the insurance company and FCIC to process this form to: provide insurance; provide reinsurance; determine eligibility; determine the correct parties to the agreement; determine and collect premiums or other monetary amounts (including administrative fees and over payments); and pay benefits. The information furnished on this form will be used by Federal agencies, FCIC employees, insurance companies, and contractors who require such information in the performance of their duties. The information may be furnished to: FCIC contract agencies, employees and loss adjusters; reinsured companies; other agencies within the United States Department of Agriculture; the Department of Treasury including the Internal Revenue Service; the Department of Justice, or other Federal or State law enforcement agencies; credit reporting agencies and collection agencies; other Federal agencies as requested in computer matching programs; and in response to judicial orders in the course of litigation. The information may also be furnished to congressional representatives and senators making inquiries on your behalf. Furnishing the information required by this form is voluntary; however, failure to report the correct and complete information requested may result in rejection of this form; rejection of any claim for indemnity, replanting payment, or other benefit; ineligibility for insurance; and a unilateral determination of any monetary amounts due.

NONDISCRIMINATION STATEMENT

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To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice or TDD). USDA is an equal opportunity provider and employer.

