Food Loss Reimbursement Request

Name:	**Product MFG:**
Address:	**Model #:**
	Serial #:
Phone #:	**Date of failure:**
Alt #:	**Total Amount Requested: $**
SR #:	**Program:**

Below, please provide the estimated cost of your food loss by food group due to your unit's failure to cool. Your plan will reimburse you for the cost of perishable food items and medications up to the limit of your endorsement. (Please fill in at least one of the fields below in order for your request to be processed.)

Dairy and Cheese	**$**
Meat, poultry & fish	**$**
Fruit and vegetables	**$**
Medication	**$**

All of the information provided on this claim form is true and accurate to the best of my knowledge and represents my actual losses.

_____ _____

Signature **Date**

Please fill out form in its entirety and send to:
Email: claimscustomerissues@asurion.com
Fax: 703-738-7058
or
Mail: PO Box 2034
Great Falls, MT 59403

Your claim will be processed within 5 business days of your product repair being completed.