SUTTER
INSURANCE COMPANY

1301 Redwood Way, Petaluma, CA 94954-1136
Mailing Address: P. O. Box 808004, Petaluma, CA 94975-8004
Phone: (707) 793-0808 * Facsimile (707) 793-0909

Date: _____________

To: _________________________________
Company: _________________________ **Fax No.:** ________________________

From: **Claims Department – Sutter Insurance Company**
Fax No.: **707-793-0909**
Email: **claimsemail@sutterinsurance.com**

Re: **Loss History Requests For Sutter Insurance Insureds**
Policy(ies): ____

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Message:

Please be advised that before we can honor your request for loss history information on the above we must have the following:

To protect the privacy of our customers, Sutter Insurance Company requires a written authorization from our Insured in order to issue a loss history. Please list all policy #'s to be processed. Attached you will find an authorization form (SC-146) which must be completed and signed by our insured and returned to our office by mail, fax or email.

Please refer to the California Insurance Code; Article 6.6 Insurance and Privacy Protection Act, Section 791.06 and 791.13 and Title 10, California Code of Regulations, Section 2689.1 through 2689.24.

Should you have any questions or comments, please do not hesitate to contact this office.

*****PLEASE NOTE: THE REQUESTED LOSS HISTORY WILL BE SENT TO THE INSURED UNLESS OTHERWISE DIRECTED BY THE INSURED.*****

Please be advised that we do not release reserve information.

Thank you.

Claims/Clerical

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AUTHORIZATION FOR RELEASE OF LOSS HISTORY INFORMATION

TO: Claims Department - Sutter Insurance Company
Fax: (707) 793-0909
Email: claimsemail@sutterinsurance.com

From: ______________________@__________________________Phone_________________
(Name) (Company Name)

RE: _______________________________________
(Named Insured)

Policy Number(s): ***Please list any & all policy numbers / time period***

____

This is my full authorization to release a claim loss history on the listed policy(ies) to:

☐ Named Insured & Fax# ____
Email: ____

☐ Insurance Broker's Name (Required)________________________
Insurance Broker's Fax# __________________Email:_____________________

☐ General Agent's Name (Required)__________________________
General Agent's Fax#____________________Email: claims@imcoinsurance.com

This authorization does not authorize release of any specific records or documents in your claim file(s). This authorization expires upon the completion of this request. A photocopy of this authorization is as valid as an original.

This authorization is in compliance with the California Insurance Code; Article 6.6 Insurance and Privacy Protection Act, Section 791.06 and 791.13, and Title 10, California Code of Regulations, Sections 2689.1 through 2689.24.

In an effort to fight insurance fraud, this authorization allows us to confirm and verify the requested information.

____________________ ____________________________________
Date Insured Signature (Signature MUST match signature on the application for insurance)

____
Name (**Please Print**)

****THIS FORM MUST BE COMPLETED IN ITS ENTIRETY PRIOR TO THE ISSUANCE OF THE REQUESTED INFORMATION****