BST LLP Insurance	Claim Referral Form
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Loss Type:	No-Fault	Business Interruption	Loss of Use	Employee Dishonesty	Other
Insured:					
Claimant:					
Claimant's Addr	ess:				
Claimant's Occu	pation:				
Claim No:					
Policy No:					
Date of Loss:					
Loss Period:					
Policy Limits (Monthly):					
Insurance Company:					
Claim Rep/Adju	ster:				
Address:					
Phone:					
Fax:					
Email:					
Attorney/Public Adjuster:					
Contact:					
Address:					
Phone:					
Fax:					
Email:					

BST LLP Telephone: (518) 459-6700 or (800) 724-6700 E-Fax: (888) 456-2049 Email: Charles Amodio @ <u>camodio@bstco.com</u> or Jennifer Isaacs @ <u>jisaacs@bstco.com</u> Regular Mail: 26 Computer Drive West, Albany, New York 12205

Please enclose NYS Form NF-7, NYS Form NF-2, and copy of policy and declaration page, if available. In addition, please enclose copies of income tax returns and/or other financial records.

