SEAVIEW INSURANCE COMPANY

AUTHORIZATION FOR RELEASE OF LOSS HISTORY INFORMATION

****PLEASE COMPLETE THIS FORM IN ITS ENTIRETY TO AVOID DELAYS****

IMPORTANT NOTE:
We answer all requests in the order received. Rush requests will not be honored. Please allow AT LEAST FIVE (5) WORKING DAYS (excluding Weekends & Holidays) before following up on the request below.

Named Insured: _____

DBA: _____

Current/Most Recent Policy #: _____

Prior Year Policy #: _____

Prior Year Policy #: _____

Prior Year Policy #: _____

This is my full authorization to release a claim loss history for the policy (or policies) listed above to:

☐ Named Insured (Insured's signature **is not required** if mailed to the insured at last address on file.)

Email Address (Insured's signature is required): _____

If you have a New Mailing Address (**Insured's verifiable signature is required**):

Street Address: _____

City: _____

State: _____ Zip Code: _____

☐ Insurance Broker (**Insured's verifiable signature is required if not the Broker of Record on file**):

Business Name: _____

Recipients Name: _____

Email Address: _____

California Insurance Code 679.7 allows us to send the insured's loss history to the insured or their broker of record without the insured's written authorization. Therefore, if this form is requesting that the loss history be provide to anyone other than the insured or their broker of record on file, it must be signed by the insured and the signature must match the signature on file. If it does not match, we will ONLY mail a copy of the requested loss history to the insured directly.

_____
Insured's Name (Print Clearly)

_____ _____
Insured's Signature- This signature **MUST** match the signature on your application. A copy of the **Authentication Documentation** must be attached to this request when the form is digitally signed (i.e., DocuSign). **Date (required)**

**** PLEASE NOTE THAT SEAVIEW DOES NOT SELL YOUR INFORMATION TO ANYONE ****