INVENTORY

DATE OF LOSS	DATE
Insured:	Claim No.:
Location:	Policy No.:

ALL COLUMNS TO BE COMPLETED ON EACH ITEM-IF UNKNOWN, SO INDICATE * BILLS, CANCELED CHECKS, OTHER DOCUMENTATION

1	2	3	4	5	6	7		8	9	10	11	12
Item No.	Quan-tity	Brand Name	Manufacturer	Series Model or Style No	Identification Description of Item (Name, Type)	Purchase Veri-fication Attached Yes	No	Date Purchased or Age	Insured's Claimed Cost/Value	Replacement Cost	Depreciation	Actual Cash Value Market Value Resale Value