UNIVERSAL INSURANCE COMPANY
A Member of the SEIBELS BRUCE GROUP, INC.
COMMERCIAL LINES

Post Office Box 25687
770 Highland Oaks Drive (27103)
Winston-Salem, NC 27114-5687
Ph: 1-800-288-8050 Fax: 1-866-810-5676

Statement of No Losses

PLEASE READ BEFORE SIGNING

As a condition prior to the reinstatement of my policy, I, the undersigned, state that no loss has occurred for which coverage might be claimed under this policy number _____ during the period beginning at 12:01 AM on the cancellation or expiration date of _____ and ending at _____ am/pm on today's date of _____.

I understand that Universal Insurance Company is relying upon this statement of no losses in order to reinstate my policy with no lapse in coverage. I further understand that if a loss has occurred for which coverage might be claimed under the above policy on or between the dates and times shown above, the reinstatement granted by Universal Insurance Company is rescinded and no coverage exists under the above policy as of 12:01 AM on the cancellation or expiration date shown above.

I agree to pay any reinstatement fee to the Company, if applicable, which is in addition to any premium required to reinstate my policy. Further, I understand and agree that my payment will be applied first to the reinstatement fee and the remainder of my payment will be applied to any premium I may owe. I agree and understand that if my check, credit card, debit card, ATM card, or other method of payment used for payment for this reinstatement is returned for insufficient funds or not honored for any reason, the reinstatement granted by Universal Insurance Company is rescinded and no coverage exists under the above policy as of 12:01 AM on the cancellation or expiration date shown above.

Note: Please be advised if Universal Insurance Company becomes obligated to make any payment under the reinstated policy for any loss occurring within the period for which this statement of no losses is given, the Company will seek reimbursement from you to the fullest extent allowed by law and seek any criminal or civil remedy which may be allowed by law.

Witness Signature	Named Insured Signature
Agency Name	Date Signed
Agency Number	Named Insured (PLEASE PRINT)

ATTENTION: _____ **COMMENTS:** _____

*** If uploading payment for reinstatement, a signed Statement of No Losses must be faxed to UIC at 1-866-810-5676 ***

U-81 (07/05)