



**TERRORISM RISK INSURANCE PROGRAM
INITIAL NOTICE OF INSURED LOSS**

Pursuant to 31 C.F.R. 50.52, this notice is required to be submitted to Treasury when the incurred aggregate insured losses (including reserves for “incurred but not reported”) for an insurer, or collectively for a group of affiliated insurers, exceed an amount equal to 50 percent of the Program Year insurer deductible. One form is to be submitted based on insured losses incurred for all certified acts of terrorism that occurred to date in the Program Year. An updated form may be requested, eg., should there be subsequent occurrences of certified acts in the same Program Year. In order to receive payment of the Federal share of compensation, the insurer must enroll in the Treasury, Financial Management Service, Automated Standard Application for Payments (ASAP) system. Further information can be obtained via the internet at <http://www.fms.treas.gov/asap/index.html>.

Insurer or Insurer Group Name: _____

NAIC Insurer (or Group) Number (or TIN if no NAIC #): _____

List all affiliated insurers with premium subject to Terrorism Risk Insurance Act of 2002:

<u>Name</u>	<u>NAIC # (or TIN if no NAIC #)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(insurers may add more lines as needed)

Program (calendar)Year: _____ ISO/PCS Catastrophe Code(s) _____

Estimated aggregate insured losses for the act(s) of terrorism: \$_____

Estimated insurer deductible for Program Year: \$_____ (see Certification of Loss Schedule A for guidance, even if Schedule A not submitted at this time)

Estimated Federal Share of Compensation: \$_____ (90% of amount in Excess of Deductible)

Point of contact for loss and compliance certifications and for payments of Federal share of compensation (in the case of affiliated insurers, a single insurance entity among the affiliated group designated to act as the single point of contact must be supplied):

Contact's Name: _____

Contact's Title: _____

Insurer Name: _____

Mailing Address: _____

Telephone Number(s): _____

Fax Number(s): _____

E-mail Address: _____

Optional Schedule A "Declaration of Direct Earned Premium and Insurer Deductible" attached (Y or N)? _____

Initial Notice of Insured Loss submitted by:

Name: _____

Title: _____

Signature: _____

Date: _____

Notice Under the Paperwork Reduction Act

We estimate it will take you about 60 minutes to complete this form. However, you are not required to provide information requested unless a valid OMB control number is displayed on the form. Any comments or suggestions regarding this form should be sent to the Terrorism Risk Insurance Program Office, 1425 New York Avenue, NW, Suite 2100, Washington, DC 20220. Do not send completed form to this address. Submit forms according to instructions provided at www.treas.gov/trip.