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## FAX TRANSMITTAL FORM

Date/Time: \_\_\_\_\_

Agency: \_\_\_\_\_

Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_

Year/Make/Model: \_\_\_\_\_

Full VIN#: \_\_\_\_\_

Policy #: \_\_\_\_\_

Deductible: \_\_\_\_\_

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Circle all that apply:

Windshield Repair

Windshield Replace

Side/Back Glass Replacement

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Additional Information: \_\_\_\_\_

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