

GENERAL LIABILITY NOTICE OF CLAIM

DATE (MM/DD/YYYY)

INSURED			CONTACT	
NAME AND MAILING ADDRESS	INSURANCE CARRIER		NAME (First, Middle, Last)	
	POLICY NUMBER		PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
	POLICY PERIOD		E-MAIL ADDRESS	
PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	TO		WHEN TO CONTACT	
SOCIAL SECURITY # OR FEIN	AGENT NAME & CODE NUMBER			
OCCURRENCE				
DATE NOTIFIED OF OCCURRENCE	DATE OF OCCURRENCE	TIME OF OCCURRENCE	PREVIOUSLY REPORTED <input type="checkbox"/> YES <input type="checkbox"/> NO	
LOCATION OF OCCURRENCE	DESCRIPTION OF OCCURRENCE			
TYPE OF LIABILITY CLAIM				
PREMISES: INSURED IS <input type="checkbox"/> OWNER <input type="checkbox"/> TENANT <input type="checkbox"/> OTHER:		TYPE OF PREMISES		
OWNER'S NAME AND ADDRESS (If not Insured)		OWNERS PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		
PRODUCTS: INSURED IS <input type="checkbox"/> MANUFACTURER <input type="checkbox"/> VENDOR <input type="checkbox"/> OTHER:		TYPE OF PRODUCT		
MANUFACTURER'S NAME AND ADDRESS (If not Insured)		MANUFACTURERS PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		
WHERE CAN PRODUCT BE SEEN?				
OTHER LIABILITY INCLUDING COMPLETED OPERATIONS (Explain)				
INJURED/PROPERTY DAMAGED				
NAME AND ADDRESS (Injured/Owner)	DATE OF BIRTH	OCCUPATION	PRIMARY PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	FATALITY <input type="checkbox"/> YES <input type="checkbox"/> NO	SECONDARY PHONE <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
	WHERE TAKEN?		WHAT WAS INJURED DOING?	
DESCRIPTION OF INJURY				

DESCRIPTION OF PROPERTY AND DAMAGE (Type, model, etc.)		WHERE CAN PROPERTY BE SEEN?	WHEN CAN PROPERTY BE SEEN?
ESTIMATED LOSS AMOUNT			
DID YOU SECURE VIDEO SURVEILLANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		DID YOU TAKE PHOTOGRAPHS OF THE LOSS, INJURIES OR SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
IF YES TO THE ABOVE, PLEASE PROVIDE THE CONTACT INFORMATION FOR WHO POSSESSES THE SURVEILLANCE:		IF YES TO THE ABOVE, PLEASE PROVIDE THE CONTACT INFORMATION FOR WHO POSSESSES THE PHOTOGRAPHS:	
DID YOU RECEIVE MEDICAL BILLS, LETTER FROM AN ATTORNEY AND/OR SUIT DOCUMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		WERE THE POLICE, FIRE DEPARTMENT AND/OR AMBULANCE CALLED TO THE SCENE OF THE INJURY AND/OR LOSS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
IF YES TO THE ABOVE, PLEASE PROVIDE THE CONTACT INFORMATION FOR WHO POSSESSES THE DOCUMENTS:		IF YES TO THE ABOVE, PLEASE PROVIDE THE CONTACT INFORMATION FOR THE EMERGENCY RESPONDER:	
WITNESSES			
NAME & ADDRESS		BUSINESS PHONE	RESIDENCE PHONE
ADDITIONAL INFORMATION			
REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER