Liability Claim Form

	Date of Loss: ___/___/_______ Time of Loss: ___________
Business Location	Location of Loss: ______________________ Address: ______________________ City: ______________________ State: ___
Loss Description	Type of Loss: ______________________ Description/**Location of Loss**: Was Weather involved? ☐ Yes ☐ No If Yes, Describe the weather conditions at the time of loss:
Claimant Contact Information	Claimant Name: ______________________ Claimant Address: ______________________ City: ______________________ State: ___ Zip: ___________ Home Ph: ___________ Work Ph: ___________ Cell Ph: ___________
Injury Information	Complaint of Injuries: Any Medical Bills? ☐ Yes ☐ No *If Yes please attach.*
Witness Information	EMPLOYEES Name: ______________________ Address: ______________________ City: ______________________ State: ___ Zip: ___________ Home Ph: ___________ Work Ph: ___________ Cell Ph: ___________ Name: Address: ______________________ City: ______________________ State: ___ Zip: ___________ Home Ph: ___________ Work Ph: ___________ Cell Ph: ___________ CUSTOMER Name: ______________________ Address: ______________________ City: ______________________ State: ___ Zip: ___________ Home Ph: ___________ Work Ph: ___________ Cell Ph: ___________

Liability Claim Form

Incident Information	
	☐ Yes ☐ No Was Assistance Offered? If Yes, by whom?
	☐ Yes ☐ No Medical Personnel/Police Contacted?
	SLIP AND FALL ONLY
	☐ Yes ☐ No Were procedures followed?
	☐ Yes ☐ No Pictures taken of loss location or cause of loss?
	☐ Yes ☐ No Diagram of loss location created?
	☐ Yes ☐ No Are salting/shoveling logs maintained? If Yes please attach copy
	Other
	☐ Yes ☐ No Can you obtain item in question?
	☐ Yes ☐ No Pictures taken of loss location or cause of loss?
	☐ Yes ☐ No Was there also property damage at the same time?
	☐ Yes ☐ No Is a Lawyer involved? If Yes attach copy of letter of representation if possible

Customer Injury & Building Damage Report

	Store Number: ___________________________ Owner/Operator Name: ___________________________ Date of Accident/Incident: / / Time: Location: ___________________________
Customer Information	Customer Name: ___________________________ Customer Address: ___________________________ City: ___________________________ State: ___ Zip: ____________ Home Ph: ________________ Work Ph: ________________ Cell Ph: ________________ Occupation: ________________ Date of Birth: / /
Incident Information	Detailed description of Accident/Incident: Location of Injury: ☐ Yes ☐ No If a slip and fall due to wet mopped floor, was “Caution. Wet Floor” sign used? ☐ Yes ☐ No Was medical attention necessary? If Yes, what, where and how was treatment received?
Witness Information	**Witness 1** Name: ___________________________ Address: ___________________________ Phone: ________________ Cell Phone: ________________ **Witness 2** Name: Address: ___________________________ Phone: ________________ Cell Phone: ________________
If Vehicle was involved	**Owner:** Name: ___________________________ Address: ___________________________ Phone: ________________ Cell Phone: ________________ **Witness** Name: Address: ___________________________ Phone: ________________ Cell Phone: ________________ License Plate No: Driver’s License No: Insurance Company:

Customer Injury & Building Damage Report

Additional Comments:

Form completed by:

Name: ______________________________

Title: ______________________________

Phone: ________________

Date: / /

Report of Employee Injury

Employer Information	Store Location: ______________________ Store #: __________ Mailing Address: ______________________ City: ______________________ State: ___ Zip: __________ Policy No.: ______________________ Expiration Date: _____ / _____ / _____ (MO / DA / YR)
Injured Employee Information	Employee Name: ______________________ Employee Address: ______________________ City: ______________________ State: ___ Zip: __________ Date of Birth: __________ Social Security Number: __________ Hire Date: __________ Phone Number: __________ Age: ______ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Injured Employee Work Information	Job Title: ______________________ Wage ______________________ Hours per day worked __________ No. of Days Worked Per Week ______
Insurance Information	**American Family Insurance** Name of Business: ______________________ Doing Business As: ______________________ Agent: ______________________ Adjuster: ______________________ Phone Number: ______________________ FAX Number: ______________________
Sign	______________________ Employee's Signature — Date Reported ______________________ Supervisor's Signature — Date ______________________ Reviewing Manager's Signature — Date

Report of Employee Injury

Injury Information

Injury Date ________________________ Time ____________ ☐ AM ☐ PM

Nature of Injury ____
(scratch, cut, bruise, etc.)

Part of Body Injured ____
(left ring finger, right ankle, etc.)

Name of Designated Medical Provider or Hospital ______________________________

Pictures Included: ☐ Yes ☐ No Video CD: ☐ Yes ☐ No Other Evidence: ☐ Yes ☐ No

HOW & WHERE DID ACCIDENT HAPPEN? (STATE SPECIFIC JOB BEING DONE AND WHAT WENT WRONG. INCLUDE MACHINE/TOOL OR OBJECT CONNECTED WITH ACCIDENT.)

____
____
____
____

IF ACCIDENT WAS CAUSED BY NON-COMPANY PERSON OR BY FAULTY EQUIPMENT. GIVE NAME AND ADDRESS.

____
____
____
____

NAME OF WITNESS: ____

WHAT HAVE YOU DONE OR WILL YOU DO TO PREVENT A SIMILAR TYPE OF ACCIDENT?

____
____
____
____

Sign

I, ______________________________ have been asked by a manager if I wanted medical treatment for my injury. I have refused medical treatment on ________________.
(Date)

Employee Signature: ____

Manager Signature: ____

Witness Signature: ____