



Liability Claim Reporting Form

Reporting Information

Date Reported: _____ Time Reported: _____ Policy Effective Date: _____

Reported By: _____

Reported To: _____ Policy Number: _____

Named Insured Information:

Named Insured: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Information

Owner: _____ Phone Number: _____ Email*: _____

Manager or Management Co.: _____ Phone Number: _____ Email*: _____

Occupant: _____ Phone Number: _____ Email*: _____

***By submitting this form to report a claim, consent is hereby given to receive any and all letters and documents necessary for the adjustment of this claim delivered via email where possible.** Initials: _____

Loss Information

Location Address: _____

City: _____ State: _____ Zip: _____

Date of Loss: _____ Type of Loss: _____

Claimant Information

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Represented by an Attorney? Yes__ No__ Attorney's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Fatality? Yes __ No __

Witness Information *(use an additional sheet if more than one witness)*

Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

Description of Damage or Injuries: _____

