

General Liability Notice of Occurrence / Claim

When Finished Submit and Attach a Copy of Policy Declaration

Date:

Agent:	Date of Loss:	Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Carrier:		
	Policy Number:		
Phone:	Fax:		
E-mail Address:			

INSURED

Name of Insured (First, Middle, Last):		Insured's Mailing Address:	
Date of Birth:	Marital Status:		
Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-Mail Address:			

CONTACT Contact Insured

Name of Contact (First, Middle, Last):		Contact's Mailing Address:	
Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-Mail Address:			

OCCURRENCE

Location of Occurrence: Street:	Police of Fire Department Contacted:
City, State, Zip:	Report Number:
Country:	
Describe Location of Loss if not at Specific Street Address:	
Description of Occurrence:	

TYPE OF LIABILITY

Premises: Insured is <input type="checkbox"/> Owner <input type="checkbox"/> Tenant	Type of Premises:	
Owner's Name & Address (if not insured):	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-Mail Address:		
Products: Insured is <input type="checkbox"/> Manufacturer <input type="checkbox"/> Vendor	Type of Product:	
Manufacturer's Name & Address (if not insured):	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Where Can Product Be Seen?		

INJURED / PROPERTY DAMAGED

Name & Address (First, Middle, Last):		Employer's Name & Mailing Address:	
Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
E-Mail Address:		E-Mail Address:	
Age:	Sex:	Occupation:	
Describe Injury:			
Where Taken:			
What was Injured Doing?:			
Describe Property:			
Estimate Amount:			
Where Can Property Be Seen?:			

WITNESSES

Name and Address:	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	E-Mail Address:	
Name and Address:	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	E-Mail Address:	
Name and Address:	Primary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	Secondary Phone #:	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell
	E-Mail Address:	

REMARKS

Reported By:	Reported To: