PROPERTY AND LIABILITY REPORT

INSTRUCTIONS: 1) FORM TO BE COMPLETED BY MANAGEMENT OF INSURED
2) DO NOT USE THIS FORM TO REPORT WORKERS COMPENSATION CLAIMS OR AUTOMOBILE ACCIDENTS
3) FAX FORM TO 812-474-2184 ATTENTION: COMMERCIAL CLAIMS ADMINISTRATOR

Insured Name& Address: ______________________ Phone #: ______________

Insured Contact Person: ______________

Date of Incident: ______________ Time of Incident: ______________________

Address Incident Happened : ______________________________________

Type of Incident:

* ( ) Injury * Name of Injured: ______________ Date of Birth: ________
or Person Owning Damaged Property

( ) Vandalism * Address: ______________________________

( ) Theft * City, State, Zip Code: ______________________________

( ) Wind * Phone #: Home ______________ Work ______________

( ) Water Cell ______________

( ) Fire * What part of the body was injured? ______________________

( ) Damage to someone else's property. What type of Property? ______________

( ) Other ______________

Name of Hospital/Medical Facility injured was taken to (if applicable) ______________

Witnesses (if any) to incident:
Name ______________ Address ______________________
City, State, Zip Code ______________________________
Phone#: Home ______________ Work ______________ Cell ______________
(List additional witnesses on separate sheet)
Were Authorities contacted (fire/police/ambulance) Yes___ No___. If yes, who ________ Report #: ________

Description of Incident:

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Other Remarks:

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Person Completing Report ______________________ Date of This Report ______________