

LIABILITY CLAIM REPORT FOR OTHER THAN AUTOMOBILE

POLICY	Important – Designate type of policy and provide appropriate number:					
	<input type="checkbox"/> Farm-Guard II/III <input type="checkbox"/> Home-Guard II/III <input type="checkbox"/> Personal Liability II/III <input type="checkbox"/> Mobile Home-Guard II/III <input type="checkbox"/> OLT II/III <input type="checkbox"/> Country Home II/III			<input type="checkbox"/> FG I <input type="checkbox"/> DHG <input type="checkbox"/> DMHG <input type="checkbox"/> Personal Liability I <input type="checkbox"/> Business Sure-All <input type="checkbox"/> General Liability (CPP) <input type="checkbox"/> Garage Liability (Use Auto, GMRC 917 for moving vehicle accident)		
	Mutual Policy No. _____			Policy No. _____		
Effective Date: _____			Expiration Date: _____			
INSURED	Name(s)				Home Phone	
	DBA (business name)				Business Phone	
	Street Address		City		State	Zip
TIME PLACE	Date	Time: A.M. P.M.	Weather Conditions		Township	County
	Exact Location of Accident				Owner of premises where accident occurred	
EQUIPMENT	If machinery or equipment involved, give complete description					
	Owner		Address		Zip Code	Home Phone Business Phone
	Operator		Age	Address		Zip Code
						Home Phone Business Phone
PROPERTY DAMAGE	Owner		Address		Zip Code	Home Phone Business Phone
	Driver (If vehicle)		Age	Address		Zip Code
	Kind of Property Damage (If automobile give year, make and model) – Describe damage					
	Tenant, if any		Address		Zip Code	Home Phone Business Phone
	Where is damaged property located?					Estimated Damage
INJURED	Name		Parent name, if minor		Age	Birth Date
	Address				Zip Code	Injury
	Where Taken (Name of Dr. and Hospital and address)					
	What was status of Injured – <input type="checkbox"/> Full-time Employee <input type="checkbox"/> Passenger <input type="checkbox"/> Exchange Help <input type="checkbox"/> Part-time Employee <input type="checkbox"/> Temporary Employee <input type="checkbox"/> Guest <input type="checkbox"/> Named Person <input type="checkbox"/> Other Does Injured reside in insured's household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No Does Injured reside on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No Does INSURED have Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Any other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
LOSS – Give Complete Details						
WITNESSES	(Name, address and phone number)					

THIS REPORT IS AS FULL, COMPLETE AND TRUE AS I AM ABLE TO MAKE

X _____
 Submitted by: Insured Claimant Insured's Agent Other _____
 Phone: (_____) _____

DATE _____ Time _____ A.M. P.M. CC _____

"A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information or helps to commit a fraud against an insurer commits a crime."