



GENERAL LIABILITY CLAIM REPORT FORM

Policy # _____

Location: _____

Address: _____

Phone Number: _____

Date of Incident: _____ Time of Incident: _____ a.m./p.m.

Location of Loss on Premises: _____

Description of Incident: _____

INJURED PARTY:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Guest: Yes: _____ No: _____

Describe Injury: _____

Medical Attention: Yes: _____ No: _____ Where: _____

Social Security Number: _____ Date of Birth: _____

PROPERTY OWNER / GUEST:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Guest: Yes: _____ No: _____

Description of Property: _____

Description of Damage: _____

Police/Fire Dept.Contact: _____

WITNESS:

Name: _____

Address: _____

Telephone: _____

WITNESS:

Name: _____

Address: _____

Telephone: _____

Email REPORT to:

Claims@RiskPointins.com

Any questions, call:

971-282-4315

PLEASE PUT NAME OF POLICY HOLDER IN SUBJECT LINE OF EMAIL