



Name of Person Reporting: _____ Telephone: _____

ADDRESS INFORMATION

Name of the Company: _____

Address of the Company: _____

Contact Name: _____

Telephone Number of Loss Location: _____

Site Code (if applicable): _____

ACCIDENT INFORMATION

Date and Time of Accident: ___/___/___ _____ am pm

Address where Accident Occurred: _____

Description of the Incident:

[Large empty box for incident description]

Were Authorities Contacted? (i.e. Police, Fire, Ambulance) Yes No

If Yes, who? _____

Was a Report Number given? Yes No

If Yes, list number: _____

Were any Safeguards provided? Yes No Were they in use at the Time of the Accident? Yes No

In the event of a Fatality, what is your OSHA number? _____



ALLIED NORTH AMERICA

GENERAL LIABILITY

FIRST REPORT OF CLAIM

CLAIMANT INFORMATION

Name of the Injured Party: _____

Is the Injured Party: Male Female

Address of the Injured Party: _____

Home Telephone: _____

Work Telephone: _____

Social Security: _____

Date of Birth: _____

Covered by Other insurance: Yes No If Yes, Company Name: _____

Marital Status: (check one) Single Married Separated Divorced Widowed

Number of Dependents: _____

Contact Name: _____

Telephone Number: _____

INJURY INFORMATION

Were any injuries incurred? Yes No What part of the body? _____

Give a description of the injuries:

What treatment was given? (please check) No Medical Treatment Minor On-Site Remedies

Minor Clinic or Hospital Emergency Evaluation Hospitalization for more than 24 Hours

Name of the Treating Physician: _____

Address of the Treating Physician: _____



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GENERAL LIABILITY
FIRST REPORT OF CLAIM

INJURY INFORMATION (continued)

Telephone Number of Treating Physician: _____

Name of the Treating Hospital/Clinic: _____

Address of the Treating Hospital/Clinic: _____

Telephone Number of the Treating Hospital/Clinic: _____

WITNESS INFORMATION

Name of a Witness to the Incident: _____

Address of the Witness: _____

Telephone Number where the Witness can be Reached: _____

CARRIER INFORMATION

Name of Carrier: _____

Policy Number: _____ Policy Inception/Expiration: _____



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GENERAL LIABILITY

FIRST REPORT OF CLAIM

Write or type below anything related to the incident you would like to add.