

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: 971-282-4304

PLEASE PUT NAME OF POLICY HOLDER IN SUBJECT LINE OF EMAIL