

Incident Report Form

CLAIMS REPORTING PROCEDURE - REPORT CLAIMS IMMEDIATELY!

If you have a question concerning whether to report an incident or claim, call your broker.

NONPROFIT / INSURED – Complete all items to the best of your ability, sign and date page 2, and immediately give it to your supervisor.

Supervisor – Fax this Incident Report Form to your insurance broker immediately.

Important: Retain any equipment or furniture which caused or contributed to an injury until it can be inspected by an insurance representative. If in doubt – report it! If you have any questions concerning whether to report an incident or claim, call your broker.

HOW DO YOU KNOW WHEN AN INCIDENT REQUIRES A CLAIM TO BE REPORTED?

1. There's been an accident
2. Someone has been hurt
3. Property has been damaged
4. You think someone ought to know "just in case"

IF YOU NEED TO REPORT A CLAIM:

1. Complete the appropriate reporting form: Incident Report Form

General Information

Name of Nonprofit Organization			Policy Number	
Name of Contact		Title		
Nonprofit Address – Street		City	State	Zip
Business Phone # ()	Ext.	Business Fax # ()	E-mail Address	

Incident Information

Date of Incident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Incident AM / PM	Did the incident occur on organization's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location of Incident (if possible, take pictures of the area with a digital or disposable camera)				
Description of Incident (A brief factual account of the incident; include who was involved, how the incident occurred and what action is being taken in response to the incident. Use the back of the sheet if more space is needed.)				

Witness Information

	Name and Address	Daytime Phone	Email Address	DOB
1.				
2.				

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Claimant Information

1. Name of Injured Party	DOB	<input type="checkbox"/> Employee	<input type="checkbox"/> Client	<input type="checkbox"/> Volunteer	<input type="checkbox"/> Visitor
		<input type="checkbox"/> Other -			
Address - Street	City	State	Zip		
Home Phone # ()	Business Phone # ()	Email Address			
Description of Injury (nature and extent of; please be specific):					
Transported by Ambulance <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and Phone # of Hospital or Doctor, if applicable				

Observations of Nonprofit

Claimant's Attire/Description of Clothing (i.e., shorts, t-shirt)	Type of Shoes	Was Claimant carrying anything? (if yes, what) <input type="checkbox"/> No <input type="checkbox"/> Yes -
Describe claimant's demeanor when making the report (i.e., agitated, in obvious or no obvious pain, able to move around while describing what happened, etc.)		

(use the back of the form or attach an additional sheet of paper if needed)

PRINT NAME OF INDIVIDUAL COMPLETING THE FORM

SIGNATURE

DATE