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**LEGAL DEPARTMENT**

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File No. \_\_\_\_\_

Claimant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Complete Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Incident: \_\_\_\_\_ Location: \_\_\_\_\_

Briefly explain what happened: \_\_\_\_\_

\_\_\_\_\_

Names and addresses of witnesses: \_\_\_\_\_

\_\_\_\_\_

Was a police report made? \_\_\_\_\_ Incident Report Number: \_\_\_\_\_

Ambulance called? \_\_\_\_\_ Were you taken to the hospital? \_\_\_\_\_

Doctor consulted? \_\_\_\_\_ Doctor's name: \_\_\_\_\_

Briefly describe the injuries/damages sustained (attach damaged property and receipts, if possible): \_\_\_\_\_

\_\_\_\_\_

Do you have insurance? \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Claimant

Dated: \_\_\_\_\_

Return with all expenses and bills incurred as a result of this claim.