



LIABILITY CLAIM FIRST REPORT FORM

Name of insured _____

Address of insured _____

Name of claimant _____

Address of claimant _____

Telephone/fax of claimant _____

Person to contact for claimant _____

Date of incident/injury _____

Location _____

Authority contacted _____

Describe incident/injury _____

Describe property damage (type, model, etc.) _____

Estimated amount of loss _____

Where property can be seen by company adjuster _____

The original complaint letter and/or summons should be sent to our office immediately, including the original accompanying envelope.

Please fax the completed form to our claims department to:
 NY 212-683-2740 LA 323-464-7348