

CLAIM REPORT

To comply with the terms of your insurance policy, you must, in the event of an accident complete this form and fax to 608-788-7012

Insured:	
Address:	
Phone:	Fax:
Current Policy Number:	Policy Effective Date:

Claimant's Name: _____

Claimant's Address: _____

Claimant's Phone: _____

Date of Incident: _____

Location of Incident: _____

Description of Incident: _____

Date first notified of incident: _____

How were you notified: _____

Are you responsible for the cause of the incident? _____ If so, why?

Was there any other responsible party involved? _____ If yes, who? _____

CLAIM REPORT

List any damages and amounts along with the source that you received this information from:

Fax any correspondence you have received relating to this incident along with this report.

This form has been completed by: _____