LIABILITY (NON-AUTOMOBILE) STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: (301) 453-7400 | **FAX:** (301) 453-7060
EMAIL: claims@adventistrisk.org

TO BE COMPLETED BY INSURED'S REPRESENTATIVE

DIVISION:

▷ INSURED ENTITY:

NAME:

TELEPHONE | BUSINESS: RESIDENTIAL:

ADDRESS: CITY: COUNTY: POST CODE:

▷ LOCATION OF INSURED PREMISES:

ADDRESS: CITY: COUNTY: POST CODE:

▷ TIME & PLACE:

DAY	MONTH	YEAR	TIME			
				AM		PM

ADDRESS: CITY: COUNTY: POST CODE:

▷ INJURED PERSON:

FIRST NAME: M.I. SURNAME: AGE: OCCUPATION:

TELEPHONE | BUSINESS: RESIDENTIAL: RELATIONSHIP TO INSURED:

ADDRESS: CITY: COUNTY: POST CODE:

EMPLOYED BY: WHAT WAS INJURED DOING WHEN HURT?

▷ THE INJURY:

NATURE & EXTENT OF INJURY:

WHERE WAS INJURED TAKEN AFTER ACCIDENT? NAME OF DOCTOR:

WHY WAS INJURED ON PREMISES?

PROBABLE DISABILITY: HAS INJURED RESUMED WORK? ☐ YES ☐ NO

▷ THE PROPERTY DAMAGE:

OWNER:

TELEPHONE | BUSINESS: RESIDENTIAL: ESTIMATED COST OF REPAIR:

ADDRESS: CITY: COUNTY: POST CODE:

LIST DAMAGE:

▷ WITNESSES:

FIRST NAME: M.I. SURNAME:

TELEPHONE | BUSINESS: RESIDENTIAL:

ADDRESS: CITY: COUNTY: POST CODE:

▷ DESCRIPTION OF ACCIDENT:

▷ NAME OF POLICE AUTHORITY TO WHOM ACCIDENT WAS REPORTED: LOCATION:

BADGE# REPORT DATE (DD/MM/YYYY):

▷ SIGNATURE OF INSURED'S REPRESENTATIVE: TITLE: DATE OF SIGNING (DD/MM/YYYY):