

## Claimant/Witness Statement

Date of Report \_\_\_\_\_ Property \_\_\_\_\_

(Do not abbreviate)

Date of Incident \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

Weather Condition \_\_\_\_\_

Name of Injured Party \_\_\_\_\_

Resident

Homeowner

Occupant

Guest

unknown

Injured Party Address \_\_\_\_\_

Street

City

State

Zipcode

Occupant/Resident Name(s) \_\_\_\_\_

Occupant/Resident Address \_\_\_\_\_

Street

City

State

Zipcode

Occupant/Resident Phone Number (h) \_\_\_\_\_ (w) \_\_\_\_\_

Location where incident occurred \_\_\_\_\_

Name of any Witness \_\_\_\_\_

Witness Address \_\_\_\_\_

Street

City

State

Zipcode

Witness Phone Numbers (h) \_\_\_\_\_ (w) \_\_\_\_\_

Description of what happened (Detail who, what, when, how.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you feel negligence was involved? If so, why? \_\_\_\_\_

\_\_\_\_\_

Attending Physician, address and phone number \_\_\_\_\_

\_\_\_\_\_

Doctors statements or estimates (circle one) attached will follow

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Corporate Use Only

Date received: Copy/Faxed \_\_\_\_\_ Original \_\_\_\_\_

Insurance Agent: \_\_\_\_\_ Notified ON: \_\_\_\_\_

\_\_\_\_\_ Record Only \_\_\_\_\_ Insurance Claim \_\_\_\_\_ R. Adm \_\_\_\_\_ Pres \_\_\_\_\_ EVP. \_\_\_\_\_ RM

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