

NON - AUTOMOBILE LIABILITY ACCIDENT NOTICE

POLICY NUMBER

CLAIM NUMBER

POLICY PERIOD

AGENCY

Insured's name: _____ Phone number: _____

Insured's address: _____

Date of accident: _____ Time of accident: _____ M.

Injured person's name: _____ Age: _____ Social security number: _____

Address: _____ Phone number: _____

Occupation: _____ Employer's name: _____

Relationship to Insured: _____ What was injured doing prior to accident? _____

Nature and extent of injury: _____

Where was injured taken after accident? _____

Physician's name: _____ Prognosis: _____

Has injured missed any work as a result of the accident? _____ If yes, how much? _____

Name of owner of the property: _____ Phone number: _____

Owner's Address: _____

Estimated cost of repair: \$ _____

Witness name: _____ Phone number: _____

Witness address: _____

Witness name: _____ Phone number: _____

Witness address: _____

Description of accident: _____

Were the police contacted? _____ If yes, what department? _____ Officer's name: _____

Signature: _____

Signature Date: _____