



**Liability Incident Report - Bodily Injury**

<b>INSURED</b>	<p><b>Name</b> _____ <b>Phone #</b> _____</p> <p><b>Address</b> _____ <b>Fax #</b> _____</p> <p>_____ <b>Email</b> _____</p> <p><b>Policy #</b> _____</p>
<b>TIME AND PLACE OF INCIDENT</b>	<p><b>Date</b> _____ <b>Time</b> _____ a.m./p.m.</p> <p><b>Exact Place of Incident</b> _____</p> <p>_____</p> <p><b>When, and to whom was the incident reported?</b> _____</p> <p>_____</p>
<b>PERSON INJURED</b>	<p><b>Name</b> _____ <b>Phone #</b> _____</p> <p><b>Address</b> _____ <b>Fax #</b> _____</p> <p>_____ <b>Email</b> _____</p> <p><b>DOB</b> _____ <b>SS#</b> _____</p> <p><b>Nature and extent of injuries</b> _____</p> <p>_____</p> <p><b>If medical aid was rendered, give name and address of doctor</b></p> <p>_____</p> <p>_____</p>

<b>FULL DESCRIPTION OF INCIDENT</b>													
<b>WITNESSES</b>	Whenever possible, please obtain names and addresses of witnesses, bystanders or individuals in the immediate vicinity who may have seen the accident or heard statements made by any of the people involved.												
	<table> <tr> <td><b>Name</b></td> <td>_____</td> <td><b>Phone #</b></td> <td>_____</td> </tr> <tr> <td><b>Address</b></td> <td>_____</td> <td><b>Fax #</b></td> <td>_____</td> </tr> <tr> <td></td> <td>_____</td> <td><b>Email</b></td> <td>_____</td> </tr> </table>	<b>Name</b>	_____	<b>Phone #</b>	_____	<b>Address</b>	_____	<b>Fax #</b>	_____		_____	<b>Email</b>	_____
	<b>Name</b>	_____	<b>Phone #</b>	_____									
	<b>Address</b>	_____	<b>Fax #</b>	_____									
	_____	<b>Email</b>	_____										
<b>INDIVIDUAL COMPLETING REPORT</b>	<table> <tr> <td><b>Name</b></td> <td>_____</td> <td><b>Phone #</b></td> <td>_____</td> </tr> <tr> <td><b>Address</b></td> <td>_____</td> <td><b>Fax #</b></td> <td>_____</td> </tr> <tr> <td></td> <td>_____</td> <td><b>Email</b></td> <td>_____</td> </tr> </table>	<b>Name</b>	_____	<b>Phone #</b>	_____	<b>Address</b>	_____	<b>Fax #</b>	_____		_____	<b>Email</b>	_____
	<b>Name</b>	_____	<b>Phone #</b>	_____									
	<b>Address</b>	_____	<b>Fax #</b>	_____									
		_____	<b>Email</b>	_____									
<b>Relationship to Injured</b>	_____												
<b>DECLARATION</b>	I/We declare that the information given in this form is true and complete to the best of my/our knowledge and belief.												
	I/We further authorize any individual or entity holding any records (including any statements taken) or knowledge of me/us which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery thereunder to furnish such records or knowledge to RiskCap or its authorized representatives. A photocopy of this authorization will be considered as effective and valid as the original.												

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_