Rockingham Claim Reporting

General Liability Intake Form

Client Name:			**Contract Number:**		
Reporter Information					
First Name:			Last Name:		
Title:	Phone:		Ext:		
Client Location Information					
Location Number:			Location Name:		
Street Address:					
City:	State:		Zip Code:		
Phone:			Ext:		
Is this the loss location? Yes		No			
Incident Information					
Date of Incident:	Time of Incident:	AM		PM	
Date Employer Notified:					
Incident Description:					
Incident Location Information (If different from above)					
Incident Location Name:					
Street Address:					
City:	State:		Zip Code:		
Authority Information					
Authority Name:	Phone:		Ext:		
Authority Report Number:					
Property Information					
Property Description:					
Damage Description:					
Damage Estimate Amount:					
Owner Information					
Owner Type: Select One					
Name:					
Street Address:					
City:	State:		Zip Code:		
Phone:			Ext:		
Other Insurance Information					
Carrier:			Phone Number:		
Involved Party Information					
First Name:	MI:		Last Name:		
Home Phone:					
Home Address:					
City:	State:		Zip Code:		
Date of Birth:			Gender: Select One		
Marital Status: Select One			Relationship to Client: Select One		
Injury Information					
Injury Description:					
Cause:			Body Part:		
Nature:					

Medical Treatment

Admitted to Hospital? Yes	No	
Hospital / Clinic Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Transportation Type: Select One		

Witness Information

Name:		
Address:		
City:	State:	Zip Code:
Phone:		

Contact Information

First Name:	MI:	Last Name:
Phone:	Ext:	Email Address:

Comments/Remarks:

ATLAS
An IRPS Company