Incident Report Form

CLAIMS REPORTING PROCEDURE

If you have a question concerning whether to report an incident or claim, call your broker or the AMS Insurance Services, Inc. Claims Department at 800-359-6422.

NONPROFIT / INSURED – Complete all items to the best of your ability, sign and date page 2, and immediately give it to your supervisor.

Supervisor – Fax this Incident Report Form to your **insurance broker** immediately.

Important: Retain any equipment or furniture which caused or contributed to an injury until it can be inspected by an insurance representative.

BROKER – Attach this Incident Report Form to a completed *ACORD* and fax it to the AMS Insurance Services, Inc. Claims Department at (877) 442-8153.

If a claim needs to be reported after business hours or on the weekend, call (866) 718-1947.
This number is reserved for true claims emergencies after business hours and weekends.

General Information

Name of Nonprofit Organization			NIAC/ANI-RRG Policy Number
Name of Contact		Title	
Nonprofit Address – Street	City	State	Zip
Business Phone # Ext. ( )	Business Fax # ( )	E-mail Address	

Incident Information

Date of Incident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Incident AM / PM	Did the incident occur on organization's premises? ☐ Yes ☐ No
Location of Incident (if possible, take pictures of the area with a digital or disposable camera)			
Description of Incident (A brief factual account of the incident; include who was involved, how the incident occurred and what action is being taken in response to the incident. Use the back of the sheet if more space is needed.)			

Witness Information

	Name and Address	Daytime Phone	DOB
1.			
2.			

Alliance Member Services

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Alliance of Nonprofits for Insurance
Risk Retention Group

www.InsuranceforNonprofits.org

Claimant Information

1. Name of Injured Party	DOB	☐ Employee ☐ Client ☐ Volunteer ☐ Visitor ☐ Other –
Address – Street	City	State Zip
Home Phone # ( )	Business Phone # ( )	
Description of Injury (nature and extent of; please be specific):		
Transported by Ambulance ☐ Yes ☐ No	Name and Phone # of Hospital or Doctor, if applicable	

Observations of Nonprofit

Claimant's Attire/Description of Clothing (i.e., shorts, t-shirt)	Type of Shoes	Was Claimant carrying anything? (if yes, what) ☐ No ☐ Yes –
Describe claimant's demeanor when making the report (i.e., agitated, in obvious or no obvious pain, able to move around while describing what happened, etc.)		

(use the back of the form or attach an additional sheet of paper if needed)

Claimant Information

2. Name of Injured Party	DOB	☐ Employee ☐ Client ☐ Volunteer ☐ Visitor ☐ Other –
Address – Street	City	State Zip
Home Phone # ( )	Business Phone # ( )	
Description of Injury (nature and extent of; please be specific):		
Transported by Ambulance ☐ Yes ☐ No	Name and Phone # of Hospital or Doctor, if applicable	

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(use the back of the form or attach an additional sheet of paper if needed)

PRINT NAME OF INDIVIDUAL COMPLETING THE FORM **SIGNATURE** **DATE**