

SUPERVISORY CODE # _____ LOCATION CODE # _____
 TO BE FILLED OUT UPON NOTIFICATION BY COMPLAINT AND DISTRIBUTED WITHIN 24 HOURS

GENERAL LIABILITY INCIDENT / CLAIM REPORT ONLY

(NOT TO BE USED FOR WORKERS' COMPENSATION OR VEHICLE INCIDENTS OR CLAIMS)

INSURED PCO	COMPANY NAME		ADDRESS		PHONE ()
	NAME				COMPLAINANT PHONE ()
COM- PLAIN- ANT	ADDRESS				
	DATE IT OCCURRED	TIME	AM PM	WHERE DID IT OCCUR?	
TO BE COM- PLETED FOR INCIDENT OR CLAIM	DATE INSURED PCO NOTIFIED		BY WHOM?		
	DESCRIPTION OF INCIDENT OR CLAIM. EXPLAIN WHAT HAPPENED (Include pesticides used where applicable)				
DAMAGE	DESCRIPTION OF DAMAGE				AMOUNT OF DAMAGE
INJURED PERSON(S)	NAME	AGE	SEX	ADDRESS	PHONE ()
	INJURY			DOCTOR/HOSPITAL	
WITNESSES	NAME			ADDRESS	PHONE ()

Does this incident/claim involve pesticides? YES NO Pesticide Used _____

THIS IS AN INCIDENT REPORT DATE OF REPORT _____

THIS IS A CLAIM REPORT REPORTED BY _____

Send This Incident/Claim Report To:
 Crawford & Company/Broadspire
 Attn: CPS Dedicated Unit
 1503 LBJ Freeway, Suite 600
 Dallas, TX 75234

Phone: 1-800-708-4277
 Fax: 1-877-630-0788