



LIABILITY (NON-AUTOMOBILE) STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: 1-888-951-4ARM (4276) | FAX: (301) 680-6878
EMAIL: claims@adventistrisk.org

TO BE COMPLETED BY INSURED'S REPRESENTATIVE

DIVISION:

▷ INSURED ENTITY:

NAME:
TELEPHONE | BUSINESS: RESIDENTIAL:
ADDRESS: CITY: STATE: ZIP CODE:

▷ LOCATION OF INSURED PREMISES:

ADDRESS: CITY: STATE: ZIP CODE:

▷ TIME & PLACE:

MONTH	DAY	YEAR	TIME
			AM PM

ADDRESS: CITY: STATE: ZIP CODE:

▷ INJURED PERSON:

FIRST NAME: M.I. LAST NAME: AGE: OCCUPATION:
TELEPHONE | BUSINESS: RESIDENTIAL: RELATIONSHIP TO INSURED:
ADDRESS: CITY: STATE: ZIP CODE:
EMPLOYED BY: WHAT WAS INJURED DOING WHEN HURT?

▷ THE INJURY:

NATURE & EXTENT OF INJURY:
WHERE WAS INJURED TAKEN AFTER ACCIDENT? NAME OF DOCTOR:
WHY WAS INJURED ON PREMISES?
PROBABLE DISABILITY: HAS INJURED RESUMED WORK? YES NO

▷ THE PROPERTY DAMAGE:

OWNER:
TELEPHONE | BUSINESS: RESIDENTIAL: ESTIMATE COST OF REPAIR:
ADDRESS: CITY: STATE: ZIP CODE:
LIST DAMAGE:

▷ WITNESSES:

FIRST NAME: M.I. LAST NAME:
TELEPHONE | BUSINESS: RESIDENTIAL:
ADDRESS: CITY: STATE: ZIP CODE:

▷ DESCRIPTION OF ACCIDENT:

▷ NAME OF POLICE AUTHORITY TO WHOM ACCIDENT WAS REPORTED: LOCATION:
BADGE# REPORT DATE (MM/DD/YYYY):

▷ SIGNATURE OF INSURED'S REPRESENTATIVE: TITLE: DATE OF SIGNING (MM/DD/YYYY):