



# LIABILITY (NON-AUTOMOBILE) STATEMENT OF LOSS

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## 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):