Liability Incident Report - Bodily Injury

INSURED	Name ____________________ Address ____________________ ____________________ Policy # ____________________	Phone # ____________ Fax # ____________ Email ____________
TIME AND PLACE OF INCIDENT	Date ____________________ Exact Place of Incident ____________________ When, and to whom was the incident reported? ____________	Time ________ a.m./p.m.
PERSON INJURED	Name ____________________ Address ____________________ ____________________ DOB/SS# ____________________ Nature and extent of injuries ____________________ If medical aid was rendered, give name and address of doctor	Phone # ____________ Fax # ____________ Email ____________

FULL DESCRIPTION OF INCIDENT	
WITNESSES	**Whenever possible, please obtain names and addresses of witnesses, bystanders or individuals in the immediate vicinity who may have seen the accident or heard statements made by any of the people involved.** **Name** ______ **Phone #** ______ **Address** ______ **Fax #** ______ ______ **Email** ______
INDIVIDUAL COMPLETING REPORT	**Name** ______ **Phone #** ______ **Address** ______ **Fax #** ______ ______ **Email** ______ **Relationship to Injured** ______
DECLARATION	I/We declare that the information given in this form is true and complete to the best of my/our knowledge and belief. I/We further authorize any individual or entity holding any records (including any statements taken) or knowledge of me/us which is/are relevant to the settling of this claim and/or the Insurer's rights of recovery thereunder to furnish such records or knowledge to RiskCap or its authorized representatives. A photocopy of this authorization will be considered as effective and valid as the original.

DATE ______ SIGNATURE ______

Return this form to Security America
(866) 315-3838 • (877) 865-0003 Fax