BOVARD INSURANCE GROUP LOSS REPORTING FORM
Property, General Liability, Auto, Work Comp

Name of Insured: ______________________________

Contact for additional information ______________________________ Phone ______________

Date of incident ____________ Time of incident __________

Location of incident ______________________________

Description of incident ______________________________

PROPERTY CLAIM:
Description of property damaged ______________________________

GENERAL LIABILITY CLAIM:
Name, address & phone # of party claiming damages ______________________________

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Damages or injuries claimed by other party ______________________________

AUTO CLAIM:
Your vehicle (including year, make & VIN) ______________________________

Damage to your vehicle ______________________________

Where is vehicle now? ____________________ Your driver's name ____________________

Authority contacted ______________ Case # __________ Violations/citations ______________

Name, address, phone # of other driver ______________________________

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Description of other vehicle ______________ Damages to other vehicle ______________

Names & extent of any injuries ______________________________

Names & phone #s of witnesses ______________________________

WORKERS COMPENSATION:

Name of injured employee ______________________________

A first report of injury form has been completed: Yes __ No __ (To send the completed first report of injury form or to request a blank form send an email to lfreeman@bovardinsurancegroup.com or fax to 913-529-1137)

______________________ ______________ ____________
Name of person completing form Phone # Date

Return to: Liz Freeman Fax: 913-529-1137 Telephone: 913-529-1130 Toll free: 866-307-3079
Email: lfreeman@bovardinsurancegroup.com