

**Church Mutual Insurance Company, S.I.**

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www.churchmutual.com

**ACCIDENT REPORT**

(NOT TO BE USED FOR AUTOMOBILE OR WORKERS' COMPENSATION)

*Please furnish the following information for prompt handling of your claim.  
You may call this information in to our office or you may fax or mail this form to us.*

**CLAIM NOTIFICATION/POLICYHOLDER INFORMATION**

Date Reported \_\_\_\_\_  
Reported by: (Name) \_\_\_\_\_ (Title) \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
Phone: (Church) \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_  
Account No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Effective Date \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.  p.m.  
Insured's Name (as it appears on policy) \_\_\_\_\_  
Address 1 (Street) \_\_\_\_\_  
Address 2 (Street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Are you insured with any other company?  No  Yes Company? \_\_\_\_\_

**ACCIDENT INFORMATION**

Location of Accident (Street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Police Dept. reported to (if any) \_\_\_\_\_ Report No. \_\_\_\_\_  
Violation issued \_\_\_\_\_  
Description of Accident - Describe fully - Include rough sketch if possible. (Use additional paper if necessary) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NOTE: It is important that any article, part, or appliance causing the accident be carefully preserved.

**INJURED OR OWNER OF DAMAGED PROPERTY**

Name of Injured or Owner of Damaged Property \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Parent/Guardian of minor child \_\_\_\_\_ Phone No.: Home \_\_\_\_\_ Work \_\_\_\_\_  
Address (Street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Are you insured under any medical accident policy?  No  Yes Company? \_\_\_\_\_  
By whom are you employed? \_\_\_\_\_  
Injuries claimed \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address (Street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Name of facility where injured was taken \_\_\_\_\_ Phone No. \_\_\_\_\_  
Address (Street) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Was injured transported by Ambulance?  No  Yes

**WITNESSES (USE ADDITIONAL PAPER IF NECESSARY)**

It is critical to give full name and address of every person who knows anything about the accident.

Name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**STATE - SPECIFIC FRAUD WARNING STATEMENTS FOR CLAIM FORMS - LIABILITY/ACCIDENT**

**Arizona** "For your protection, Arizona law requires the following statement to appear on this form:  
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California** "For your protection California law requires the following to appear on this form:  
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

**Colorado** "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies."

**Florida** "Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree."

**Maine** "It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits."

**New Jersey** "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York** "Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation."

**Pennsylvania** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is crime and subjects such person to criminal and civil penalties"

**Alaska, Arkansas, Delaware, District of Columbia, Idaho, Indiana, Kentucky, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, and Virginia**

"For your protection, these states require the following wording on this form:  
Any person who knowingly and with intent to defraud an insurer files a statement of claim containing false, inflated, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud and may be subject to civil fines, criminal penalties, and denial of insurance benefits."

**Applicable in All States**

For your protection, review your policy for an explanation of the insured's duties in the event of a loss. Failure to comply with these duties may void your policy.

Your signature will assist in prompt handling of this claim

Name (print) \_\_\_\_\_

Phone: Home ( \_\_\_\_\_ ) \_\_\_\_\_ Work ( \_\_\_\_\_ ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_