The Insurance Carrier will need the following information to establish a claim. Please complete as much as possible.

Liability Claim Reporting Form

Office Use:
Client Code _____

Today's Date: _____ **Policy No.:** _____

Named Insured (Include DBA if applicable): _____

Mailing Address of Insured: _____

Contact Name: _____ Phone No.: _____

Email Address: _____

Date of Loss: _____ Time of Loss: _____

Address where the Incident Occurred (incl City & State):_____

Describe what happened: _____

_____

_____

Police Contacted? ☐Yes ☐No Fire Dept. Contacted? ☐Yes ☐No

Department Name: _____ Phone No.:_____ Case No.: _____

Name of Claimant/Injured: _____

Address: _____

Phone No.:_____ Email: _____

Witness Information:

Name: _____ Phone No.:_____

Address: _____

Witness Statement: _____

Have you been Served with Court Documents? ☐ Yes ☐ No

Questions &/or Special Issues to be Addressed: _____

_____

Form Completed By: _____ Phone No.:_____

Title: _____ Date: _____

Email to claims@pennbrookins.com

Pennbrook Insurance Services, Inc.
142 Sansome Street, 4th Floor San Francisco, CA 94104
T. (415) 820-2200 | F. (415) 394-8332 | License # 0622553
www.pennbrookins.com