Incident Report Form

This form should be completed if someone has been injured or property (including motor vehicles) has been damaged.

MARKEL®
P.O. Box 2009, Glen Allen, VA 23058-2009
800-362-7535 Fax: 855-662-7535
newclaims@markelcorp.com

Today's Date: _____ Policy Number: _____

Section I – Insured/Organization Information

Insured/Organization Name: _____

Mailing Address: _____

Location Address (if different than mailing) _____

Phone Number: (_____) _____ Contact Person: _____

Section II – Property Damage Information

Owner of Damaged Property: _____

Address: _____

_____

Phone Number: (_____) _____ Damaged Property Description: _____

_____

Section III – Injured Party Information

Name of the Injured Person: _____

Address: _____

_____

Phone Number: (_____) _____ Alt. Phone Number: (_____) _____ Date of Birth: __/__/__

Parent or Guardian (if a minor) _____

Description of injury: _____

_____

_____

Section IV – Incident Information

Date of Damage/Injury: __/__/__ Time of Damage/Injury: _____ a.m. p.m.

1. Exact location of the incident: _____
2. What activity was going on? _____
3. Detailed description of the accident: _____

_____

_____

_____

_____

Please provide the names and information of witnesses:

a. Full Name: _____
Address: _____
_____
Phone #: _____ Age: _____

b. Full Name: _____
Address: _____
_____
Phone #: _____ Age: _____

4. After the incident, what action was taken? (Please be specific.) _____
_____
_____

5. If applicable, provide the name of the facility where the injured party was taken: _____

6. How was the injured party transported? _____

7. Who was called? _____ When? _____ a.m. p.m.

Additional Information or Comments: _____
_____
_____
_____

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 subjects the person to criminal [NY residents: substantial] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee, and Virginia, insurance benefits may also be denied.

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

Please provide the following signatures:

_____ _____
Printed Name of the person completing this report Title — Signature of the person completing this report

_____ _____
Printed Name of the supervisor on duty — Signature of the supervisor on duty

_____ _____
Printed Name of the parent/guardian of the injured party (if minor) — Signature of the parent/guardian of the injured party (if available)

Additional Information or Comments: _____
_____
_____

Please fax this completed form to 855-662-7535 or email newclaims@markelcorp.com