

GENERAL LIABILITY ACCIDENT REPORT

Date of this report: _____

Insured: _____ Address: _____

Date of loss: _____ Time loss occurred: _____ a.m. p.m.

Location of loss: _____
(Address, City, State & Zip Code)

Claimant's name: _____ Phone: (____) _____
(Area code) + phone number

Claimant's address: _____
(Mailing address, City, State & Zip Code)

Description of loss: _____

Employees involved (if any):

Name: _____ Phone: (____) _____
(Area Code) + phone number

Name: _____ Phone: (____) _____
(Area Code) + phone number

If loss involves bodily injury, did claimant seek medical attention: yes no

If yes, name and address of doctor or hospital: _____

If loss involves damage to claimant's property, describe property: _____

Witnesses: _____ Employee? yes no
Name, area code, phone number

Witnesses: _____ Employee? yes no
Name, area code, phone number

Name of person completing this report: _____

Phone: (____) _____
(Area Code) + phone number

**FAX COMPLETED FORM TO: Helen Watson @ MHBT – 972-376-8101 or Phone: 972-770-1653
or E-mail to helen_watson@mhbt.com**