GENERAL LIABILITY - PERSONAL INJURY CLAIM FORM

Indicates required field *

Claimant Information

Claimant Name:* _____

Street Address:* _____

City/State/Zip Code:* _____

Telephone Number: _____ (Home) _____ (Work) _____ (Mobile)

Injured Person Information

☐ Injured Person same as claimant

Name of injured person: _____

Street Address: _____

City/State/Zip Code: _____

Telephone Number: _____ (Home) _____ (Work) _____ (Mobile)

General Claim Information

Date & Time of Incident:* _____ (Date)
_____ (Time)

Describe in Detail How Incident Occurred:* _____

_____

_____

_____

Describe injuries:* _____

_____

_____

_____

Street Address of Incident or Location of Incident: * _____

City/State of Incident: _____

Police Report Number: _____

Witness Information

Name of Witness to Incident: _____

Street Address: _____

City/State/Zip Code: _____

Telephone Number: _____ _____ _____

(Home) (Work) (Mobile)

Treating Physician/Facility

Name of Facility: _____

Name of Treating Physician: _____

Street Address: _____

City/State/Zip Code: _____

Telephone Number: _____

Additional Information

Additional Comments: _____

_____

_____

_____

Signature Information

VERIFICATION BY CERTIFICATION

☐ Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.*

Preparer's Name:*_____

Claimant Signature: *_____

Date:*_____

Preparer Signature: _____ Date: _____

City of Chicago Claims Unit
2 N. LaSalle Street, Suite 350
Chicago, IL 60602
(312) 744-5650 Voice
(312) 744-5449 Fax
cityofchicagoclaims@ccmsi.com