



Mississippi Institutions of Higher Learning General Liability Claim Reporting Form

University: _____

Address: _____

Contact Person: _____ Phone: _____

Date of Loss or Occurrence: _____ Time of Loss: _____

Describe Damage/Loss: _____

How Did Damage/Loss Occur? _____

Employee Responsible: _____ Department: _____

If property was damaged, please complete the following:

Owner of Property: _____ Phone: _____

Address: _____

Description of Property: _____

Where can property be seen? _____

If injuries are involved, please complete the following:

(1) Injured Party's Name: _____ Phone: _____

Address: _____

Description of Injury: _____

Was person taken to doctor/hospital? Yes _____ No _____

If yes, where? _____

(2) Injured Party's Name: _____ Phone: _____

Address: _____

Description of Injury: _____

Was person taken to doctor/hospital? Yes _____ No _____

If yes, where? _____

(3) Injured Party's Name: _____ Phone: _____

Address: _____

Description of Injury: _____

Was person taken to doctor/hospital? Yes _____ No _____

If yes, where? _____

List the names and addresses of any witnesses:

(1) Witness's Name: _____ Phone: _____

Address: _____

(2) Witness's Name: _____ Phone: _____

Address: _____

(3) Witness's Name: _____ Phone: _____

Address: _____

Name of Person Completing Form

Date Form Completed

Send Completed Form to:

Mail: AmFed
P.O. Box 1380
Ridgeland, MS 39158-1380
Fax: 601-427-1588
Email: froi@amfed.com