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