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