CLAIMS REPORTING FORM

Insured Information:

Name Insured:		
Policy No:	Contact Person:	
Address:		
City:	State:	Zip Code:
Business Telephone:	Home Telephone:	
E-Mail Address:	Cell Telephone:	

Claim Information:

Date of Loss:	Time of Loss:
Location of Loss:	
Claimant Name:	Contact Info:
Description of Loss: (Please provide a summary of the facts surrounding the loss as you know of them):	
If suit papers were received, please provide the following:	
Date Received:	Taken By:

Please attach copy of any relevant supporting information to the claim (demand letter, suit papers, etc) and fax with claim form to:
ACS/AIChE Professional Liability Claims Administraor, 202-263-4001

Submit