Northern Illinois Conference
OF THE UNITED METHODIST CHURCH

Claim Forms

Claim forms are included for property, general liability, auto and workers' compensation.

Insurance Carrier Contact List

Line of Coverage	Carrier Contact Information	Policy Number
Property Insurance	Travelers Property & Casualty Company of America: 800.238.6225 Fax: 800.QUIK-FAX (800.784.5329)	KTK-CMB-0J08847-A-24
General Liability	Philadelphia Insurance Company Phone: 800.765.9749 Fax: 800.685.9238 Email: claimsreport@phly.com	PHPK2638687
Auto Liability & Auto Physical Damage	Philadelphia Insurance Company Phone: 800.765.9749 Fax: 800.685.9238 Email: claimsreport@phly.com Auto glass claims: 877. 443.9893	PHPK2638687
Workers' Compensation	Hartford Insurance Phone: 800.327.3636 Fax: 800.347.8197 Email: Lossconnect@thehartford.com	83WEBT9716

Travelers Property Claim Form

WORKSHEET FOR PROPERTY TELEPHONE REPORTING

ACCOUNT INFORMATION

CALLER'S PHONE NUMBER & EXTENSION	CALLER'S TITLE AND NAME	LOSS STATE (STATE WHERE LOSS OCCURRED)

SUBSIDIARY NAME AND ADDRESS

SUBSIDIARY MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

DID THE LOSS OCCUR AT THE LOCATION ADDRESS? (IF "NO", ADDRESS WHERE LOSS OCCURRED)

☐ YES ☐ NO

PARENT COMPANY/INSURED'S NAME	LOCATION CODE	POLICY SYMBOL AND NUMBER

LOSS INFORMATION

DATE AND TIME OF LOSS

FULL DESCRIPTION OF LOSS (INCLUDE SPECIFICS OF WHERE IT OCCURRED, SUCH AS A WAREHOUSE, STOCKROOM, DEPARTMENT)

DID THE LOSS INVOLVE:

BUILDING (REAL PROPERTY) DAMAGE? IF YES,

DESCRIPTION OF DAMAGE TO BUILDING

IS ANY INTERIOR SECTION OF THE BUILDING NOW EXPOSED TO THE OUTDOORS AND UNPROTECTED?

CAN THE BUILDING BE OCCUPIED?

DO YOU HAVE A WRITTEN ESTIMATE OR REPAIR BILL FOR BUILDING? IF YES, AMOUNT

CONTENTS (PERSONAL PROPERTY) DAMAGE? IF YES,

DESCRIPTION OF DAMAGE TO CONTENTS

DO YOU HAVE A WRITTEN ESTIMATE OR REPAIR BILL FOR BUILDING? IF YES, AMOUNT

ONLY GLASS OR SIGN DAMAGE?

BUSINESS INTERRUPTION?

WITNESSES (NAMES, ADDRESSES, AND PHONE NUMBERS)

AUTHORITIES (NAME, REPORT/CASE NUMBER, COUNTY, ANY VIOLATIONS/CITATIONS)

CONTACT INFORMATION

CONTACT NAME AND PHONE NUMBER, BEST TIME TO CONTACT AND WHERE TO CONTACT

ADDITIONAL NOTES/COMMENTS OR CUSTOMER SPECIFIC INFORMATION

Philadelphia General Liability Claim Form

GENERAL LIABILITY NOTICE OF OCCURRENCE / CLAIM

DATE (MM/DD/YYYY)

AGENCY	INSURED LOCATION CODE	DATE OF LOSS AND TIME ☐ AM ☐ PM
	CARRIER	NAIC CODE
	POLICY NUMBER	
CONTACT NAME:		
PHONE (A/C, No, Ext):		
FAX (A/C, No):		
E-MAIL ADDRESS:		
CODE: SUBCODE:		
AGENCY CUSTOMER ID:		

INSURED

NAME OF INSURED (First, Middle, Last)	INSURED'S MAILING ADDRESS
DATE OF BIRTH / FEIN (if applicable)	
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY E-MAIL ADDRESS:
	SECONDARY E-MAIL ADDRESS:

CONTACT

☐ CONTACT INSURED

NAME OF CONTACT (First, Middle, Last)	CONTACT'S MAILING ADDRESS
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	
WHEN TO CONTACT	PRIMARY E-MAIL ADDRESS:
	SECONDARY E-MAIL ADDRESS:

OCCURRENCE

LOCATION OF OCCURRENCE STREET:	POLICE OR FIRE DEPARTMENT CONTACTED
CITY, STATE, ZIP:	REPORT NUMBER
COUNTRY:	
DESCRIBE LOCATION OF OCCURRENCE IF NOT AT SPECIFIC STREET ADDRESS:	
DESCRIPTION OF OCCURRENCE (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)	

TYPE OF LIABILITY

PREMISES: INSURED IS ☐ OWNER ☐ TENANT ☐	TYPE OF PREMISES
OWNER'S NAME & ADDRESS (If not insured)	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:
	SECONDARY E-MAIL ADDRESS:
PRODUCTS: INSURED IS ☐ MANUFACTURER ☐ VENDOR ☐	TYPE OF PRODUCT
MANUFACTURER'S NAME & ADDRESS (If not insured)	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL / SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:
	SECONDARY E-MAIL ADDRESS:
WHERE CAN PRODUCT BE SEEN?	

AGENCY CUSTOMER ID: _____

INJURED / PROPERTY DAMAGED

NAME & ADDRESS (Injured/Owner)		EMPLOYER'S NAME & ADDRESS	
PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
PRIMARY E-MAIL ADDRESS:		PRIMARY E-MAIL ADDRESS:	
SECONDARY E-MAIL ADDRESS:		SECONDARY E-MAIL ADDRESS:	
AGE / SEX / OCCUPATION		DESCRIBE INJURY	
WHERE TAKEN		WHAT WAS INJURED DOING?	
DESCRIBE PROPERTY (Type, model, etc.)	ESTIMATE AMOUNT	WHERE CAN PROPERTY BE SEEN?	

WITNESSES

NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	
NAME AND ADDRESS	PRIMARY PHONE # ☐ HOME ☐ BUS ☐ CELL	SECONDARY PHONE # ☐ HOME ☐ BUS ☐ CELL
	PRIMARY E-MAIL ADDRESS:	
	SECONDARY E-MAIL ADDRESS:	

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

REPORTED BY	REPORTED TO

AGENCY CUSTOMER ID: _____

APPLICABLE IN ALASKA

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

APPLICABLE IN ARIZONA

For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN ARKANSAS, DELAWARE, KENTUCKY, LOUISIANA, MAINE, MICHIGAN, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH DAKOTA, PENNSYLVANIA, RHODE ISLAND, SOUTH DAKOTA, TENNESSEE, TEXAS, VIRGINIA, AND WEST VIRGINIA

Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and [NY: substantial] civil penalties. In LA, ME, TN, and VA, insurance benefits may also be denied.

APPLICABLE IN CALIFORNIA

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN THE DISTRICT OF COLUMBIA

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

APPLICABLE IN FLORIDA

Pursuant to S. 817.234, Florida Statutes, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in S. 775.082, S. 775.083, or S. 775.084, Florida Statutes.

APPLICABLE IN HAWAII

For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN IDAHO

Any person who knowingly and with the intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN INDIANA

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

APPLICABLE IN KANSAS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

AGENCY CUSTOMER ID: _____

APPLICABLE IN MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MINNESOTA

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

APPLICABLE IN NEVADA

Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a felony.

APPLICABLE IN NEW HAMPSHIRE

Any person who, with purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

APPLICABLE IN OHIO

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

APPLICABLE IN WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Philadelphia Auto Claim Form

ACORD™

Northern Illinois Conference
OF THE UNITED METHODIST CHURCH

AUTO ACCIDENT INFORMATION FORM

KEEP THIS DOCUMENT IN YOUR GLOVE COMPARTMENT

IF YOU HAVE AN ACCIDENT, use this form to record the facts about the accident, including names and address of all parties involved, and any witnesses to the accident. Give the completed form to your insurance agent or company, or provide the information by phone.

DATE OF ACCIDENT AND TIME	LOCATION OF ACCIDENT (INCLUDE CITY & STATE)
☐ AM ☐ PM	

DESCRIPTION OF ACCIDENT (USE REVERSE SIDE IF NECESSARY)

AUTHORITY CONTACTED AND REPORT #	ANY VIOLATIONS/CITATIONS AS A RESULT OF THE ACCIDENT (DESCRIBE)

PROPERTY DAMAGED (NOT YOUR VEHICLE)

DESCRIBE PROPERTY (If auto, year, make, model, plate #)		INSURANCE COMPANY
OWNER'S NAME & ADDRESS		RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):
OTHER DRIVER'S NAME & ADDRESS ☐ (Check if same as owner)		RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):
DRIVER'S LICENSE NUMBER	DESCRIBE DAMAGE	WHERECAN DAMAGE BE SEEN?

INJURED PARTIES

NAME & ADDRESS	PHONE (A/C, No)	AGE	DESCRIBE INJURY
INJURED WAS: ☐ PEDESTRIAN ☐ IN YOUR CAR ☐ IN OTHER CAR			
INJURED WAS: ☐ PEDESTRIAN ☐ IN YOUR CAR ☐ IN OTHER CAR			

WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (A/C, No)	INS VEH	OTH VEH	OTHER (Specify)

YOUR INSURED VEHICLE

YEAR	MAKE	MODEL	PLATE NUMBER	STATE

OWNER'S NAME & ADDRESS	RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):
DRIVER'S NAME & ADDRESS ☐ (Check if same as owner)	RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):

RELATION TO INSURED (Employee, family, etc.)	DATE OF BIRTH	DRIVER'S LICENSE NUMBER	STATE	PURPOSE OF USE	USED WITH PERMISSION? ☐ YES ☐ NO

DESCRIBE DAMAGE	WHERE CAN VEHICLE BE SEEN?	WHEN CAN VEH BE SEEN?	OTHER INSURANCE ON VEHICLE

YOUR INSURANCE COMPANY NAME	YOUR POLICY NUMBER	YOUR AGENT'S NAME

POLICYHOLDER INFORMATION

POLICYHOLDER'S NAME & ADDRESS	RESIDENCE PHONE (A/C, No):
	BUSINESS PHONE (A/C, No, Ext):
REMARKS	

ACORD 11 (2/95)

Hartford Workers' Compensation Claim Form

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12