



P.O. Box 3870, Glen Allen, VA 23058-3870  
(800)362-7535 Fax: (804)747-9367  
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# Incident Report Form

This form should be completed if someone has been injured or property (including motor vehicles) has been damaged.

Today's Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## Section I - Insured/Organization Information

Insured/Organization Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Location Address (if different than mailing) \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Contact Person: \_\_\_\_\_

## Section II - Property Damage Information

Owner of Damaged Property: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Damaged Property Description: \_\_\_\_\_

## Section III - Injured Party Information

Name of the Injured Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Alt. Phone Number: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Guardian (if a minor) \_\_\_\_\_

Description of injury: \_\_\_\_\_

## Section IV - Incident Information

Date of Damage/Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of Damage/Injury: \_\_\_\_\_ a.m. p.m.

1. Exact location of the incident: \_\_\_\_\_

2. What activity was going on? \_\_\_\_\_

3. Detailed description of the accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please provide the names and information of witnesses:

a. Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Age: \_\_\_\_\_

b. Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Age: \_\_\_\_\_

4. After the incident, what action was taken? **(Please be specific.)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. If applicable, provide the name of the facility where the injured party was taken: \_\_\_\_\_

6. How was the injured party transported? \_\_\_\_\_

7. Who was called? \_\_\_\_\_ When? \_\_\_\_\_ a.m. p.m.

Additional Information or Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 and subjects the person to criminal [ NY residents: substantial ] civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee, and Virginia, insurance benefits may also be denied.

I hereby certify that to the best of my knowledge and belief the information provided is true and correct and that no information which would materially affect this insurance has been withheld.

**Please provide the following signatures:**

\_\_\_\_\_  
Printed Name of the person completing this report Title

\_\_\_\_\_  
Signature of the person completing this report

\_\_\_\_\_  
Printed Name of the supervisor on duty

\_\_\_\_\_  
Signature of the supervisor on duty

\_\_\_\_\_  
Printed Name of the parent/guardian of the injured party (if minor)

\_\_\_\_\_  
Signature of the parent/guardian of the injured party (if available)

Additional Information or Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please fax this completed form to 804-747-9367  
or e-mail to MICclaims@markelcorp.com.**