GRINNELL MUTUAL REINSURANCE COMPANY
PO Box 790 • 4215 HIGHWAY 146 • GRINNELL, IA 50112-0790

CLEAR FORM

LIABILITY CLAIM REPORT FOR OTHER THAN AUTOMOBILE

POLICY

Important – Designate type of policy and provide appropriate number:

- ☐ Farm-Guard II/III
- ☐ Home-Guard II/III
- ☐ Personal Liability II/III
- ☐ Mobile Home-Guard II/III
- ☐ OLT II/III
- ☐ Country Home II/III

_____ Mutual Policy No.

_____ Association or Company No.

- ☐ FG I ☐ DHG ☐ DMHG
- ☐ Personal Liability I
- ☐ Business Sure-All
- ☐ General Liability (CPP)
- ☐ Garage Liability (Use Auto, GMRC 917 for moving vehicle accident)

_____ Policy No.

_____

Effective Date: Expiration Date:

INSURED

Name(s)				Home Phone
DBA (business name)				Business Phone
Street Address	City	State	Zip	Cell Phone

TIME PLACE

Date	Time: A.M. P.M.	Weather Conditions	Township	County
Exact Location of Accident			Owner of premises where accident occurred	

EQUIPMENT

If machinery or equipment involved, give complete description

Owner		Address	Zip Code	Home Phone / Business Phone
Operator	Age	Address	Zip Code	Home Phone / Business Phone

PROPERTY DAMAGE

Owner		Address	Zip Code	Home Phone / Business Phone
Driver (If vehicle)	Age	Address	Zip Code	Home Phone / Business Phone

Kind of Property Damage (If automobile give year, make and model) – Describe damage

Tenant, if any	Address	Zip Code	Home Phone / Business Phone
Where is damaged property located?			Estimated Damage

INJURED

Name	Parent name, if minor	Age	Birth Date	Home Phone / Business Phone
Address			Zip Code	Injury

Where Taken (Name of Dr. and Hospital and address)

What was status of Injured – ☐ Full-time Employee ☐ Passenger ☐ Exchange Help ☐ Part-time Employee ☐ Temporary Employee ☐ Guest ☐ Named Person ☐ Other

Does Injured reside in insured's household? ☐ Yes ☐ No

Does Injured reside on premises? ☐ Yes ☐ No

Does INSURED have Worker's Compensation? ☐ Yes ☐ No

Any other insurance? ☐ Yes ☐ No

LOSS – Give Complete Details

WITNESSES

(Name, address and phone number)

"A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information or helps to commit a fraud against an insurer commits a crime."

THIS REPORT IS AS FULL, COMPLETE AND TRUE AS I AM ABLE TO MAKE

X _____

Submitted by: ☐ Insured ☐ Claimant ☐ Insured's Agent ☐ Other _____

Phone: ( ) _____

DATE _____ Time _____ ☐ A.M. ☐ P.M. CC _____

GMRC 1001 1-07

Use Reverse Side for More Details

Save Submit