

CLA IMS REPORTING FORM – CUSTOMER INCIDENT
(not for reporting WC claims)

Name of injured customer: (First name)_____

(Last name)_____

Injured Customer's address: (Street)_____

(Apt#)_____

(City/State)_____

(Zip)_____

Phone#: (Home)_____

(Work)_____

Description of incident:

Date & Time of accident:_____

Location of accident:_____

Witnesses & Phone#: _____

Person's name/title reporting this claim: _____

Phone#: _____ Fax#: _____
