Accident / Incident Details

(Please complete the applicable sections)

Section A

Reported By:

Insured :

Reporter's Name : ______________________

Address : ______________________
Street Address City State Zip Code

Contact Information : Work -
Cell -

Job Title : ______________________

Supervisor : ____________ Phone # (   )   -

Other Party / Claimant Involved:

Name : ______________________

Address : ______________________
Street Address City State Zip Code

Contact Information : Home -
Work -
Cell -

Persons Involved : Customer-Vendor / Employee / Visitor

Other : ______________________

Date & Time Incident / Accident

____
Month Day Year

Time : ____________
AM / PM

Date & Time Reported

____
Month Day Year

Time : ____________
AM / PM

Location of Incident / Accident

Loss Location:

Insured Location / Worksite / Other : ______________________

Address: ______________________
Street Address City State Zip Code

Incident Type: (Check All That Applies)

- ☐ Personal Injury / Illness
- ☐ Vehicle Accident
- ☐ Property Damage
- ☐ Work Related
- ☐ Other : ____________

____

Project Description : ______________________

____

____

____

Project Name :

Full Name of Injured Party : ______________________ **Date of Birth :** ____________ **Male / Female**

Address : ______________________ **Phone Number :** ____________

Were any of the following contacted: Y = YES N = NO (Check All That Applies)

Supervisor : Y / N Name : ______________________ Phone # (   )   -

Police : Y / N Agency : ______________________ Report # : ______________________

Emergency Medical Staff : Y /N Agency : ______________________

Fire Department : Y / N Agency : ______________________ Report # : ______________________

Why Not Reported: ______________________

____

BRYSON

Employee Injury

(For Additional Info Refer To Work Comp Manual)

Section B

Cause of Injury : ______________________________

Part (s) of Body Injured : ______________________________

Multiple Injuries : Y / N Fatality : Y / N Other : ______________________________

Witness Name : ______________________________ Phone # ( ) -

Witness Name : ______________________________ Phone # ( ) -

Was Injury A Result of The Use of A Motor Vehicle : YES / NO (If yes, complete Section C)

Auto Accident Only

Section C

Driver and Vehicle Information

Insured Driver : ______________________________

Position / Title : ______________________________

Driver's License Number : ______________ State : ________

DOB : ______________ Sex : Male / Female

Address : ______________________________

____

Contact Information : Home ( ) -

Work ( ) -

Cell ( ) -

Email : ______________________________

Insured Vehicle Information:

License Plate Number : ______________ State : ________

Year : ________ Make : ______________ Model : ______________

Color : ________ Vin : ______________________________

Description of Damage : ______________________________

____

Name of Other Driver : ______________________________

Position / Title : ______________________________

Driver's License Number : ______________ State : ________

DOB : ______________ Sex : Male / Female

____

Address : ______________________________

Contact Information : Home ( ) -

Work ( ) -

Cell ( ) -

Email : ______________________________

Insured Vehicle Information:

License Plate Number : ______________ State : ________

Year : ________ Make : ______________ Model : ______________

Color : ________ Vin : ______________________________

Registered Owner : ______________________________

Policy Number : ______________________________

Policy Period : ______________ to ______________

Insurance Agent : ______________________________

Agent Phone Number : ______________________________

Property Damage Only

Section D

Cause of Damage (s) : ____________________

Building / Property Damaged : ____________________

Description of Damage : ____________________

Building / Property Owner : ____________________ Phone # (   )   -

Witness Name : ____________________ Phone # (   )   -

Witness Name : ____________________ Phone # (   )   -

Nature of Accident / Incident and Extent of Injuries / Damages

Section E

I hereby certify that the above information is true and correct to my understanding of this incident.

Print Name	Signature	Date & Time

*Return completed form to Bryson Financial within 24 Hours of Accident / Incident

Email: PCClaims@brysonfinancial.com