Incident Reporting Form

INTEGRO INSURANCE BROKERS

General Information		
Name of person reporting	Telephone No.	For reporting only ☐ Yes ☐ No
Name of person completing this form	Date (dd/mm/yyyy)	Time a.m. p.m.

Insured's Information		
Name of Insured	Address	
City/Town	Province	Postal Code
Business Telephone No. (incl. ext.)	Cellular No.	Language Spoken
Contact Name	Contact email address	

Accident Information		
Address where loss occurred		Province
Please give description of loss		
Kind of Loss	Date of Loss (dd/mm/yyyy)	Time of Loss
Were the authorities contacted (police, fire, ambulance)? ☐ Yes ☐ No	Was a report no. given? ☐ Yes ☐ No	If yes, provide number
If police/fire department contacted, provide name of officer	Division	Badge No.

Injury Information			
Name and address of injured party			
Date of Birth (dd/mm/yyyy)	Home Telephone No.	Work Telephone No.	Contact at work/home
Were any injuries incurred? ☐ Yes ☐ No	What part of the body?		
What treatment was given? (please check)	☐ No medical treatment	☐ Minor on site remedies	
☐ Minor clinic or hospital	☐ Emergency evaluation	☐ Hospitalization for more than 24 hours	
Describe the injuries			
Name and address of treating physician			Telephone No.
Name and address of treating hospital/clinic			Telephone No.
Sex ☐ Male ☐ Female	Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		No. of dependents

Witness Information			
Name of witness to the accident			
Address			
City/Town	Province	Postal Code	Telephone No.
Anything related to the accident you would like to add:			