GENERAL LIABILITY - PERSONAL INJURY CLAIM FORM

Indicates required field *

Claimant Information

Claimant Name:* ______________________________

Street Address:* ______________________________

City/State/Zip Code:* ______________________________

Telephone Number: ______________________________ (Home) ______________________________ (Work) ______________________________ (Mobile)

Injured Person Information

☐ Injured Person same as claimant

Name of injured person: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Telephone Number: ______________________________ (Home) ______________________________ (Work) ______________________________ (Mobile)

General Claim Information

Date & Time of Incident:* ______________________________(Date)
______________________________ (Time)

Describe in Detail How Incident Occurred:* ______________________________

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Describe injuries:* ______________________________

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Street Address of Incident or Location of Incident: * ______________________________

City/State of Incident: ______________________________

Police Report Number: ______________________________

Witness Information

Name of Witness to Incident: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Telephone Number: ______________________________

(Home) (Work) (Mobile)

Treating Physician/Facility

Name of Facility: ______________________________

Name of Treating Physician: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Telephone Number: ______________________________

Additional Information

Additional Comments: ______________________________

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Signature Information

VERIFICATION BY CERTIFICATION

☐ Under penalties as provided by law pursuant to Section 1-109 of the Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct.*

Preparer's Name:*____

Claimant Signature: *________________________________

Date:*____

Preparer Signature: ________________________________ Date: ____

City of Chicago Claims Unit
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Chicago, IL 60602
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