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:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Describe injuries:*

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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: ____________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________
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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