CITY OF HIGHLAND PARK
NON-WORKERS COMPENSATION ACCIDENT REPORT FORM

Please complete the sections of the report that are applicable. Please print in ink. The individual having responsibility for reporting the accident should complete the report **by the close of the work shift**. The claimant should not complete this form.

The supervisor/department head of the employee who filled out the form should complete section IX. The report shall then be forwarded to your claims coordinator **by the end of the work shift or within 24 hours**.

I. INSURED INFORMATION

NAME OF INSURED	CONTACT PERSON NAME AND PHONE NUMBER	DEPARTMENT INVOLVED

DATE OF LOSS	TIME OF LOSS ______ A.M. ______ P.M.	WAS EMPLOYEE INJURED YES _____ NO_____

LOCATION OF LOSS	EMPLOYEE NAME	EMPLOYEE STATUS __ FULL __ PART __ SEASONAL __ OTHER

POLICE OR FIRE DEPT. REPORT #	STREET/SIDEWALK CONDITIONS: ___ DRY ___ OTHER ___ WET ____ SNOW/ICE	WEATHER CONDITONS: ___CLEAR/CLOUDY ___RAIN ___SNOW ___ OTHER

II. PROPERTY DAMAGE

ITEMS DAMAGED:	AGE OF ITEM (S) DAMAGED	VIN NUMBER:	ESTIMATE OR LOSS DAMAGE $

MAKE OF OUR VEHICLE/MOBILE EQUIPMENT:	YEAR:	MODEL:	LICENSE NUMBER (S)

III. DESCRIPTION OF ACCIDENT

IS CLAIMANT MAKING A CLAIM? ___ YES ___ NO	PLEASE EXPLAIN

IV. TYPE OF ACCIDENT (Please check which applies)

SLIPS, TRIPS, FALLS ____ PROPERTY ____ POLICE PROFESSIONAL LIABILITY ____

AUTOMOBILE LIABILITY ____ EMPLOYMENT LIABILITY _____ OTHER/PLEASE EXPLAIN ____

V. CLAIMANT ACCIDENT / INJURY INFORMATION

NAME	SEX	AGE/D.O.B.

BUSINESS PHONE	HOME PHONE	ADDRESS

NATURE OF INJURY/PART OF BODY _____ FATALITY	WHAT WAS INJURED PERSON DOING?

WHERE TAKEN? (Name of hospital/clinic, address, phone number)

VI. CLAIMANT AUTOMOBILE INFORMATION

OWNER OF OTHER VEHICLE	AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN OWNER	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	VIN NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE

IS VEHICLE INSURED? ____YES ____NO	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.	WHERE VEHICLE CAN BE SEEN

VII. CLAIMANT NON-AUTO PROPERTY DAMAGE (i.e. fence, building, etc.)					
OWNER OF PROPERTY	ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY		LOCATION OF PROPERTY			
IS PROPERTY INSURED? _____YES _____NO	COMPANY/AGENCY NAME, POLICY NO. & PHONE NO.				

VIII. WITNESS INFORMATION				
NAME	AGE/D.O.B.	ADDRESS	BUSINESS PHONE	HOME PHONE
NAME	AGE/D.O.B.	ADDRESS	BUSINESS PHONE	HOME PHONE

IX. ADDITIONAL COMMENTS

Conditions (Describe any conditions or defects contributing to the accident)

Describe any unsafe acts or procedures contributing to the accident.

What precautions could have been taken to avoid accident (if any?)

Remedy (As a supervisor, what action have you taken or do you propose taking to help prevent a similar accident?)

Comments:

X____
SUPERVISOR/DEPT. MANAGER SIGNATURE & DATE

X____
CLAIMS COORDINATOR SIGNATURE & DATE

PLEASE SEND ANY SUPPORTING MATERIAL, SUCH AS AVAILABLE REPORTS, NEWSPAPER ACCOUNTS, PICTURES, REPAIR ESTIMATES AND/OR BILLS, AS SOON AS POSSIBLE.
POLICE REPORTS / AMBULANCE REPORTS / ESTIMATES OF REPAIR
NOTE: IF PROPERTY IS DAMAGED BY A CLAIMANT VEHICLE, PLEASE FILE A STATE OF ILLINOIS ACCIDENT FORM WITH THE SECRETARY OF STATE.