Sedgwick General Liability Intake Form

Email: SCMSNIC@SedgwickCMS.com Fax: 1-866-261-5795

Client Name:		**Contract Number:**	
Reporter Information			
First Name:		Last Name:	
Title:	Phone:		Ext:
Client Location Information			
Location Number:		Location Name:	
Street Address:			
City:	State:		Zip Code:
Phone:		Ext:	
Is this the loss location? Yes ☐ No ☐			
Incident Information			
Date of Incident:	Time of Incident:	AM ☐	PM ☐
Date Employer Notified:			
Incident Description:			
Incident Location Information (If different from above)			
Incident Location Name:			
Street Address:			
City:	State:		Zip Code:
Authority Information			
Authority Name:	Phone:		Ext:
Authority Report Number:			
Property Information			
Property Description:			
Damage Description:			
Damage Estimate Amount:			
Owner Information			
Owner Type: Select One			
Name:			
Street Address:			
City:	State:		Zip Code:
Phone:		Ext:	
Other Insurance Information			
Carrier:		Phone Number:	
Involved Party Information			
First Name:	MI:		Last Name:
Home Phone:			
Home Address:			
City:	State:		Zip Code:
Date of Birth:		Gender Select One	
Marital Status: Select One		Relationship to Client: Select One	
Injury Information			
Injury Description:			
Cause:		Body Part:	
Nature:			
Medical Treatment			
Admitted to Hospital? Yes ☐ No ☐			
Hospital / Clinic Name:			
Street Address:			
City:	State:		Zip Code:
Phone:		Ext:	

Sedgwick General Liability Intake Form

Email: SCMSNIC@SedgwickCMS.com Fax: 1-866-261-5795

Transportation Type: Select One		
Witness Information		
Name:		
Address:		
City:	State:	Zip Code:
Phone:		
Contact Information		
First Name:	MI:	Last Name:
Phone:	Ext:	Email Address:
Comments/Remarks:		