LIABILITY CLAIM REPORTING FORM

(USE THIS FORM IF A CLAIM POTENTIALLY INSURED BY THIS POLICY IS BEING MADE AGAINST YOU.)

1. Foster Parent _____

2. Street Address _____

   City _____ State _____ Zip _____ Telephone# _____

3. Foster Parent License # _____

4. Name of Foster Child _____

   Foster Child Date of Birth _____ (OR) Age _____ Sex _____

5. **SPECIFIC** date and time of incident _____

6. Where did incident take place? _____

7. Description of incident _____

   _____

   _____

8. PERSONAL INJURY SECTION
   (Complete this section only if a claim for INJURY is being made AGAINST you or the person named in number 4)

   Full Name of Injured Party _____Telephone # _____

   Address _____

   Age _____ Sex _____ Occupation _____

   Description of Injury _____

   Physician's Name or Medical Facility _____

9. PROPERTY DAMAGE SECTION
   (Complete this section only if a claim for PROPERTY DAMAGE is being made AGAINST you or the person named in number 4)

   Name _____ Telephone # _____

   Address _____

   Description of Damaged Property _____

   Estimated Amount of Damage _____

   Where can damages be seen? _____

10. WITNESS SECTION (LIST ANY WITNESSES TO THE INCIDENT)

    Name _____ Telephone # _____

    Address _____

11. Other remarks or comments as to fault _____

12. Has loss been reported to your insurance company? _____

    If yes, name and phone # of person reported to _____

_____ _____

Signature Date

PLEASE COMPLETE AND MAIL THIS FORM IMMEDIATELY TO:
RISK MANAGEMENT DIVISION
85 STATE HOUSE STATION
AUGUSTA, MAINE 04333
1-800-525-1252 or 287-3351

INSURANCE PROGRAM FOR FOSTER PARENTS