Risk Management Fund

Complete and Return to OSCTexas@yorkrsg.com

GENERAL AND E & O LIABILITY LOSS NOTICE

Date Completed (MM/DD/YY:)

1. MEMBER INFORMATION:

Business Name And Mailing Address	
Contact Person And Title:	Contact Phone (A/C, NO.):
Policy Number:	

2. INCIDENT INFORMATION:

Defendant's Name:	Defendant's Home Phone:	Defendant's Work Phone:
Date Of Incident (MM/DD/YY:)	Time Of Loss: ☐ AM ☐ PM	Location Of Accident (Include City And State): (NOTE: If more than one location affected, list in the REMARKS section.)

Police Contacted: Yes ☐ No ☐	Officer's Name:	Police Report Number: (please attach copy)	Lawsuit Filed? Yes ☐ No ☐ (Please attach copy.)
Description of Loss or Damage:		Work Unit/Department:	

3. CLAIMANT INFORMATION:

Name and Address 1:	Home Phone (A/C. No.):	Work Phone (A/C. No):	Social Security Number:
	DOB (MM/DD/YY):	Gender F ☐ M ☐	Occupation:
Employer's Business Name and Mailing Address			
Describe Injury (In as much detail as possible, i.e. right arm, left leg): ☐ Fatality			
Where was injured taken?	What was injured doing?		

Name and Address 2:	Home Phone (A/C. No.):	Work Phone (A/C. No):	Social Security Number:
	DOB (MM/DD/YY):	Gender F ☐ M ☐	Occupation:
Employer's Business Name and Mailing Address			

Describe Injury (In as much detail as possible, i.e. right arm, left leg): ☐ Fatality	
Where was injured taken?	What was injured doing?

4. **PROPERTY DAMAGE:**

Describe Property (Type, model, etc.):

5. **WITNESSES:**

NAMES AND ADDRESS:	Business Phone (A/C, No.)
	Residence (A/C. No.):
NAMES AND ADDRESS:	Business Phone (A/C, No.)
	Residence (A/C. No.):

6. **REMARKS:**

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TWCARMF Toll Free Phone number 800-580-8922 **Fax 614-956-2636**