IRMA NON-WORKERS COMPENSATION ACCIDENT REPORT FORM

PLEASE EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
OR SUBMIT VIA FAX -708-562-0900

Please complete the sections of the report that are applicable. 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 VIII. The report shall then be forwarded to your claims coordinator ***by the end of the work shift or within 24 hours.*** *This completed form shall then be forwarded to IRMA the* ***same day*** *the claims coordinator receives it.*

I. MEMBER INFORMATION

IRMA Member: Contact Person: Phone Number:

Department: Date of Loss: Time of Loss:

Was Employee Injured: Yes No Employee Name/Driver if Auto:

Location of Loss: Police or Fire Dept. Report #:

Street/Sidewalk Conditions: Weather Conditions:

Dry Other Wet Snow/Ice Clear/Cloudy Rain Snow Other

II. MEMBER PROPERTY DAMAGE

Items Damaged: Age of Item(s) Damaged:

Vin Number: Estimate of Damage:

Name of Our Vehicle/Mobile Equipment: Year Model:

License Number(s)

III. MEMBER DESCRIPTION OF ACCIDENT

Is Other Party Making a Claim? Yes No Please explain:

IV. CLAIMANT ACCIDENT/INJURY INFORMATION

Name: Sex: Age/D.O.B.

Address: Business Phone: Home Phone:

Nature of Injury/Part of Body: What was Injured Person Doing?

Fatality

Where Taken? (Name of hospital/clinic, address, phone number)

V. CLAIMANT AUTOMOBILE INFORMATION

Owner of Other Vehicle: Age: Phone:

Address: City: State Zip

Driver, if Other than Owner: Age: Phone

Address: City: State Zip

Make of Vehicle: Year: Model: License No:

Vin #: Area of Damage: Estimate of Damage:

Vehicle Insured: Yes No Company/Agency Name:

Policy No: Phone No. Where Vehicle Can be Seen

VI. CLAIMANT NON-AUTO PROPERTY DAMAGE (i.e. fence, building, etc.)

Owner of Property: Phone #:

Address: City: State: Zip:

Describe Damaged Property:

Location of Property

Is Property Insured: Yes No Company/Agency Name:

Policy #: Phone #:

VII. WITNESS INFORMATION

Name: Age/DOB: Address:

Bus. Phone: Home Phone:

Name: Age/DOB: Address:

Bus. Phone: Home Phone:

VII. ADDITIONAL COMMENTS

Conditions (Describe any conditions or defects contributing to this 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:

____________________________________ ____________________________________

Supervisor/Dept. Manager Signature & Date Claims Coordinator Signature & Date

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PLEASE SEND ANY SUPPORTING MATERIAL, SUCH AS AVAILABLE REPROTS, NEWSPAPER ACCOUNTS, PICTURES, REPAIR ESTIMATES AND/OR BILLS AS SOON AS POSSIBLE.
POLICE REPORTS/AMBULANCE REPORTS/ESTIMATES OF REPAIR

NOTE: IF MEMBER PROPERTY IS DAMAGED BY A CLAIMANT VEHICLE, PLEASE FILE A STATE OF ILLINOIS ACCIDENT FORM WITH THE SECRETARY OF STATE.