



PRIVILEGED AND CONFIDENTIAL INSURED-INSURER PRIVILEGE

IRMA NON-WORKERS' COMPENSATION ACCIDENT REPORT FORM

**PLEASE EMAIL ACCIDENT REPORT TO IRMA PROMPTLY – CLAIMS@IRMARISK.ORG
 OR SUBMIT VIA FAX- 708-562-0400**

Please complete the applicable sections of the report. 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 forward to their 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

NAME OF IRMA MEMBER (MUNICIPALITY)		CONTACT PERSON NAME AND PHONE NUMBER		DEPARTMENT
DATE OF LOSS	TIME OF LOSS _____ A.M. _____ P.M.		WAS EMPLOYEE INJURED YES _____ NO _____	
LOCATION OF LOSS		EMPLOYEE NAME/DRIVER IF AUTO		
POLICE OR FIRE DEPT. REPORT #	STREET/SIDEWALK CONDITIONS: ___ DRY ___ OTHER ___ WET ___ SNOW/ICE		WEATHER CONDITONS: ___ CLEAR/CLOUDY ___ RAIN ___ SNOW ___ OTHER	

II. MEMBER PROPERTY DAMAGE

ITEMS DAMAGED:	AGE OF ITEM (S) DAMAGED	VIN NUMBER:	ESTIMATE OF DAMAGE \$
MAKE 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
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IV. 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)			

V. 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 VEH	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		

VI. 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.				

VII. WITNESS INFORMATION

NAME	AGE/D.O.B.	ADDRESS	BUS PHONE ()	HOME PHONE ()
NAME	AGE/D.O.B.	ADDRESS	BUS PHONE ()	HOME PHONE ()

COMMENTS (Optional):

X _____
SUPERVISOR/DEPT. MANAGER SIGNATURE & DATE

X _____
CLAIMS COORDINATOR SIGNATURE & DATE

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