



A Head for Insurance. A Heart for Nonprofits.

Including ALLIANCE OF NONPROFITS FOR INSURANCE (ANI) &
NONPROFITS INSURANCE ALLIANCE OF CALIFORNIA (NIAC)

www.insurancefornonprofits.org

Claims Reporting Procedure

REPORT CLAIMS IMMEDIATELY!

There is no negative impact on your policy for reporting an incident.
When in doubt – report it!

If you have any questions concerning whether to report an incident or claim,
call your broker.

HOW DO YOU KNOW WHEN AN INCIDENT REQUIRES A CLAIM TO BE REPORTED?

1. There's been an accident
2. Someone has been hurt
3. Property has been damaged
4. You think someone ought to know "just in case"

IF YOU NEED TO REPORT A CLAIM:

1. Complete the appropriate reporting form:
 - Driver Accident Report Form – motor vehicle accident
 - Incident Report Form – all other accidents

An original of these forms follows this page of your policy. Additional forms are available at our secure website: www.insurancefornonprofits.org.

NOTE: Claims for North American Elite Property Insurance or NIAC Property Insurance do not require a separate form. Your insurance broker will send us an ACORD claim form.

2. Tell your insurance broker to report the claim to our Claims Department by email at: newclaims@insurancefornonprofits.org

EMERGENCY SITUATIONS

If you need to report a claim during **non-business hours** and cannot reach your broker, call 1-866-718-1947. This number should **only** be used for true claims emergencies.



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Incident Report Form

CLAIMS REPORTING PROCEDURE

If you have a question concerning whether to report an incident or claim, call your broker.

NONPROFIT / INSURED – Complete all items to the best of your ability, sign and date page 2, and immediately give it to your supervisor.

Supervisor – Fax this Incident Report Form to your **insurance broker** immediately.

Important: Retain any equipment or furniture which caused or contributed to an injury until it can be inspected by an insurance representative.

BROKER – Refer to our website for instructions on claim reporting.

If a claim needs to be reported after business hours or on the weekend, call (866) 718-1947.

This number is reserved for true claims emergencies after business hours and weekends.

General Information

Name of Nonprofit Organization			ANI/NIAC Policy Number	
Name of Contact		Title		
Nonprofit Address – Street		City	State	Zip
Business Phone # ()	Ext.	Business Fax # ()	E-mail Address	

Incident Information

Date of Incident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Incident AM / PM	Did the incident occur on organization's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Location of Incident (if possible, take pictures of the area with a digital or disposable camera)				
Description of Incident (A brief factual account of the incident; include who was involved, how the incident occurred and what action is being taken in response to the incident. Use the back of the sheet if more space is needed.)				

Witness Information

	Name and Address	Daytime Phone	Email Address	DOB
1.				
2.				

Claimant Information

1. Name of Injured Party		DOB	<input type="checkbox"/> Employee <input type="checkbox"/> Client <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor <input type="checkbox"/> Other -		
Address - Street		City	State	Zip	
Home Phone # ()		Business Phone # ()		Email Address	
Description of Injury (nature and extent of; please be specific):					
Transported by Ambulance <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Phone # of Hospital or Doctor, if applicable			

Observations of Nonprofit

Claimant's Attire/Description of Clothing (i.e., shorts, t-shirt)	Type of Shoes	Was Claimant carrying anything? (if yes, what) <input type="checkbox"/> No <input type="checkbox"/> Yes -
Describe claimant's demeanor when making the report (i.e., agitated, in obvious or no obvious pain, able to move around while describing what happened, etc.)		

*(use the back of the form or attach an additional sheet of paper if needed)***Claimant Information**

2. Name of Injured Party		DOB	<input type="checkbox"/> Employee <input type="checkbox"/> Client <input type="checkbox"/> Volunteer <input type="checkbox"/> Visitor <input type="checkbox"/> Other -		
Address - Street		City	State	Zip	
Home Phone # ()		Business Phone # ()		Email Address	
Description of Injury (nature and extent of; please be specific):					
Transported by Ambulance <input type="checkbox"/> Yes <input type="checkbox"/> No		Name and Phone # of Hospital or Doctor, if applicable			

Observations of Nonprofit

Claimant's Attire/Description of Clothing (i.e., shorts, t-shirt)	Type of Shoes	Was Claimant carrying anything? (if yes, what) <input type="checkbox"/> No <input type="checkbox"/> Yes -
Describe claimant's demeanor when making the report (i.e., agitated, in obvious or no obvious pain, able to move around while describing what happened, etc.)		

*(use the back of the form or attach an additional sheet of paper if needed)***PRINT NAME OF INDIVIDUAL COMPLETING THE FORM****SIGNATURE****DATE**



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Driver's Collision Report Form

IN THE EVENT OF A COLLISION:

NONPROFIT / INSURED Driver – Complete all items to the best of your ability, sign and date page 3, and immediately give it to your supervisor.
Supervisor – Fax this Driver's Collision Report form to your **insurance broker** immediately.

BROKER Refer to our website for instructions on claim reporting.

If a claim needs to be reported after business hours or on the weekend, call (866) 718-1947.
 This number is reserved for true claims emergencies after business hours and weekends.

Driver/Vehicle Information

Name of Driver (first and last)		Driver's Age	Driver License No.	State
Driver's Address – Street		City	State	Zip
		Telephone No. ()		
Name of Nonprofit / Employer				ANI/NIAC Policy Number
Nonprofit/Employer Contact Name		Contact Email Address		
Nonprofit / Employer Address – Street		City	State	Zip
		Telephone No.		
Make of Nonprofit's Vehicle	Body Type	Year	License Plate #	V.I.N. (last four digits)
Damage to Nonprofit's Vehicle:				

Collision Information

Date of Collision	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Collision AM / PM	Location - Street or Highway & City	
On what street were you driving?			Direction (circle one) N S E W	Speed (approximate)
On what street was other vehicle driving?			Direction (circle one) N S E W	Speed (approximate)
Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of reporting officer	Agency	Citation/Report #	
Witness #1 Name (first and last)		Telephone No. ()	Email Address	
Witness #2 Name (first and last)		Telephone No. ()	Email Address	

Description of Collision (include weather and road conditions):

(Use the back of this sheet if additional space is needed; please use the diagrams on page 3 to draw the collision)

Passenger(s) in Your Vehicle (attached additional pages if needed)

Name (first and last)	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No. ()	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ambulance called to scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of doctor or hospital			

Other Vehicle Involved

Name of Driver (first and last)		Driver License No.	State
Address - Street	City/State/Zip	Telephone No. ()	Email Address
Name of Vehicle Owner (if different than above)		Telephone No. ()	Email Address
Name of Insurance Company	Policy #	Telephone No. ()	
Year/Make of Vehicle	Body Type	License Plate No.	State
Damage to Vehicle:			
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Vehicle Involved (if an)

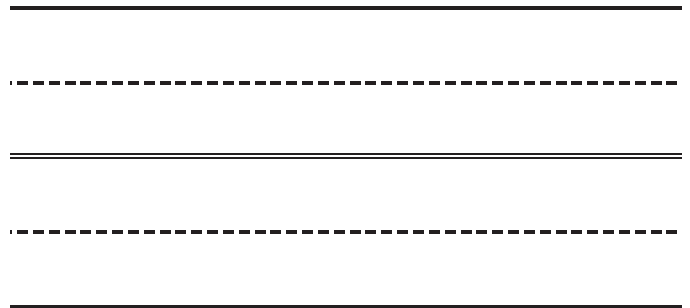
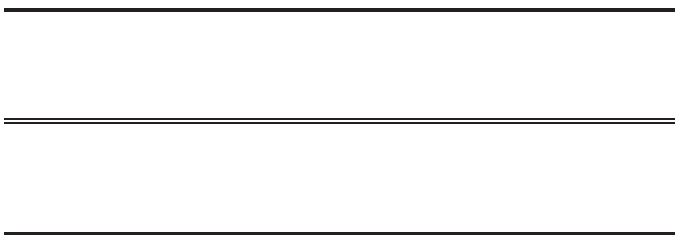
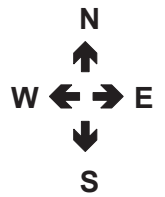
Name of Driver (first and last)		Driver License No.	State
Address - Street	City/State/Zip	Telephone No. ()	Email Address
Name of Vehicle Owner (if different than above)		Telephone No. ()	Email Address
Name of Insurance Company	Policy #	Telephone No. ()	
Year/Make of Vehicle	Body Type	License Plate No.	State
Damage to Vehicle:			
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)	Telephone No. ()	Email Address	Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

On the diagrams below, please draw the collision.

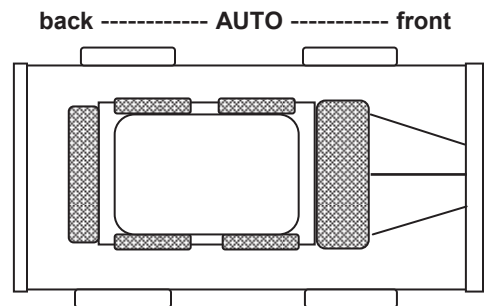
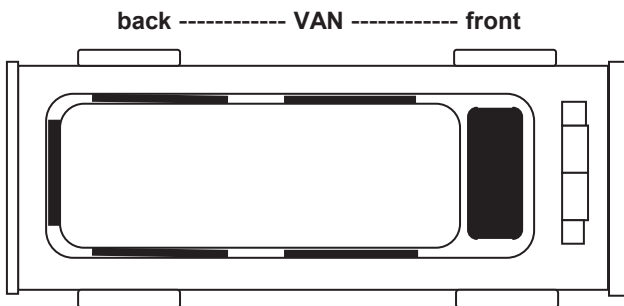
(Be sure to include any stop signs or traffic signals.)

Legend:

- V 1 ▶ Your Vehicle
- V 2 ▶ Other Vehicle
- V 3 ▶ Other Vehicle (if any)



On the overhead diagrams below, please indicate the location of damage to *your* vehicle, if any.



SIGNATURE OF DRIVER

DATE