To report a claim, please call: (844) 430 – 0811 or email: [ADOIClaims@tnwinc.com](mailto:ADOIClaims@tnwinc.com)

*Note: Any question with an asterisk (\*) is required information.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Information | | | | | | | | | | | | | |
| GB Client Number | | | | 000059 | | | | | | | | | |
| Client Name | | | | Archdiocese of Indianapolis | | | | | | | | | |
| VDN Number | | | | 2228377 | | | | | | | | | |
| Date and Time | | | | | | | | | | | | | |
| \*Incident Date | | | | Enter date. | | | | | | | | | |
| \*Insured Notified Date | | | | Enter date. | | | | | | | | | |
| Client Location | | | | | | | | | | | | | |
| \*Location Code | | | | Enter Location Code. | | | | | | | | | |
| \*Name | | | | Enter Name. | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | |
| City | Enter City. | | | \*State | | Choose State. | | | ZIP | | | Enter ZIP. | |
| Phone Number | Enter phone #. | | | | | | | | | |  | | |
| Submitter Information | | | | | | | | | | | | | |
| Name | | | | Enter Name. | | | | | | | | | |
| Title | | | | Enter Title. | | | | | | | | | |
| Email Address | | | | Enter Email. | | | | | | | | | |
| Phone Number | | | | Enter Phone #. | | | | | | | | | |
| Incident Information | | | | | | | | | | | | | |
| \* Detailed Description of Incident (Limit the description field 250 characters) | | | | Enter Description. | | | | | | | | | |
| Witnesses *(Only if any Witnesses) - can add as many as necessary* | | | | | | | | | | | | | |
| First Name | | | | Enter First Name. | | | | | Last Name | | | Enter Last Name. | |
| Home Phone | | | | Enter Phone #. | | | | | Work Phone | | | Enter Phone #. | |
| Location of Incident *(type SAME, if same as reporting location)* | | | | | | | | | | | | | |
| Location Name | | | | Enter Location Name. | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | |
| City | Enter City. | | | \*State | | Choose State. | | | | ZIP | | Enter ZIP. | |
| Authority | | | | |
| Authority Name | | | | Enter Name. | | | | | | | | | |
| Phone Number | | | | Enter Phone #. | | | | | | | | | |
| Involved Parties *(can add as many as necessary)* | | | | | | | | | | | | | |
| \*First Name | | | | Enter Name. | | | | Middle Initial | | | | | Enter Initial. |
| \*Last Name | | | | Enter Name. | | | |  | | | | | |
| Phone Number | | | | Enter Phone #. | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | |
| City | Enter City. | | | State | | Choose State. | | ZIP | | | | | Enter ZIP. |
| Birth Date | Enter date. | | | | | Date of Death (if applicable) | | | | | | | Enter date. |
| Marital Status | Choose... | | | Gender | | Choose... | | | | | | | |
| Relationship to Client (employee, spouse, self, customer, unknown, other) | | | | | | | | | | | | | Enter text. |
| Medical Provider *(Only if medical treatment rendered)* | | | | | | | | | | | | | |
| Hospital/Clinic Name | | | | Enter text. | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | |
| City | Enter City. | | | State | | Choose State. | | ZIP | | | | | Enter ZIP. |
| Phone Number | | | Enter Phone #. | | | | | | | | | | |
| Doctor Name | | | Enter Name. | | | | | | | | | | |
| Street Address | | | Enter Street Address. | | | | | | | | | | |
| City | Enter City. | | | State | | Choose State. | | ZIP | | | | | Enter ZIP. |
| Phone Number | | | Enter Phone #. | | | | | | | | | | |
| Involved Party Employer | | | | | | | | | | | | | |
| Name | | | Enter Name. | | | | | | | | | | |
| Work Phone | | | Enter Phone #. | | | | | | | | | | |
| Occupation | | | Enter text. | | | | | | | | | | |
| Involvement Type (claimant or owner; owner refers to property) | | | | | | | Enter text. | | | | | | |
| Property *(if applicable)* | | | | | | | | | | | | | |
| Third Party Property? | | | Choose... | | | | | | | | | | |
| Describe Item(s) | | | Enter text. | | | | | | | | | | |
| Damage Description | | | Enter text. | | | | | | | | | | |
| Estimated Damage | | | Enter text. | | | | | | | | | | |
| Insurance Co. Name | | | Enter text. | | | | | | | | | | |
| Policy Number | | | Enter text. | | | | | | | | | | |
| When/Where Can Be Seen *(current location of property)* | | | | | | | | | | | | | |
| Name | | | | Enter Name. | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | |
| City | Enter City. | | | State | | Choose State. | | ZIP | | | | | Enter ZIP. |
| When | Enter text. | | | | | | | Owner | | | | | Enter text. |
| Contact Information | | | | | | | | | | | | | |
| \*First and Last Name | | Enter text. | | | | | | | | | | | |
| \*Phone | | Enter Phone #. | | | | | | | | | | | |
| Notes/Additional Comments *(ie, if this is for report only)* | | | | | | | | | | | | | |
| Additional Remarks | | Enter text. | | | | | | | | | | | |
|  | | | | | | | | | | | | | |