To report a claim, please call: (844) 430 – 0811 or email: 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. |
|  |