General Liability Claim Form

Send Completed form to:
539 US Route 15 Hwy
P.O. Box 3485
Williamsport, Pennsylvania 17701
(570) 326-1921 Fax (570) 326-2951

(LEXINGTON USE ONLY)

Telephone immediate notice to Little League Baseball International

CN

Insured

Name of League

League I. D. Number
(Used as location code)

Name of League Official (please print)

Position in League

Address of League Official (Street, City, State, Zip)

Phone No. (Res.)

Phone No. (Bus.)

Time and Place of Accident

Date of Accident

Hour ☐ AM ☐ PM

Accident occured at (Street, City, State, Zip)

Arising out of Operations conducted at

Was Police Report made? If yes, where?
☐ Yes ☐ No

Description of Accident

State cause and describe facts surrounding accident (Use reverse side if needed)

Who owns Premises

Person in charge of Premises

Coverage Data

Limits	Elevator:	Products:	Cont.
BI / PD: **Med. Pay: None**	**Yes**	**Yes**	**Yes**

Policy Number:

Policy Dates:
Begin: End:

Is there any other insurance applicable to this Risk?
☐ Yes ☐ No

Property Damage

Name of Owner

Description of Property

Address (Street, City, State, Zip)

Name of Insurance Co.

Nature and Extent of Damages and Estimate of Repairs

Insured Person and Injuries:

Name

Phone No. (Res)

Address (Street, City, State, Zip)

Occupation

Age

☐ Married ☐ Single

Phone No. (Bus)

Employers Name and Address

Did you provide or authorize medical attention? ☐ Yes ☐ No

Attending Doctor's Name and Address

Description of Injury

Where was the injured taken after accident?

Probable length of Disability

Witnesses:

Name, Address, Phone Number

Name, Address, Phone Number

Name, Address, Phone Number

Date of Report:	Signature of League Official:	Position in League:

USE REVERSE SIDE FOR DIAGRAM AND ANY OTHER INFORMATION OF IMPORTANCE IN REPORTING THE ACCIDENT

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