General Liability
Fax or Email Form

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

To report a claim, please fax: Click here to enter Fax#. or email: - RPSContractorSelectClaims@gbtpa.com

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

Client Information			
*GB Client Number	040996	*Name	RPS Contractor Select

Reporting Location (Employer, Branch, Unit)					
*Location Code				Phone Number	
*Name					
Address					
City		State		Zip Code	

Submitter Information			
First and Last Name		Phone Number	
Title		Email Address	

Contact Information			
*First and Last Name		Phone Number	
*Email Address			

Incident					
*Date		Time		*Insured Notified Date	
*Detailed Description of Incident					
Location					
Is the location of the incident on the client/employer premises?					
Is Location of Incident the same as the reporting location?					
If location of Incident is different that the reporting location, complete the Location information below.					
Location Name					
Street Address					
City		*State		Zip	

Authorities Involved				
	Authority Type	Contact Name	Work Phone	Report Number
1				
2				

Witnesses				
	First Name	Last Name	Home Phone	Work Phone

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1				
2				

Involved Parties Summary

Step 1: List each involved Party separately in the table below.
Step 2: For each Involved Party, complete a separate Involved Party Information correlating the # number from this table to the Involved Party Information Table.

#	First Name	Middle Initial	Last Name	Relationship to Client	Was Party Injured?	Did Party have a Property loss?
1						
2						

Involved Party Information for Involved Party #1

First Name				Middle Initial	
Last Name				Gender	
Email Address					
Date of Birth		Marital Status		Date of Death	
Street Address					
City		State		ZIP	
Home Phone		Work Phone			

Work Details

Employer Name		Employer Phone	
Occupation		Involvement Type	

Injury Details

Type of Injury	
Part and Side of Body Injured	
Detailed Description of Injury	

Medical Treatment

Has the claimant already sought medical treatment?					
Hospital/ Clinic	Location Name				
	Street Address				
	City		*State		Zip
Physician/ Doctor/ Practitioner	Location Name				
	Street Address				
	City		*State		Zip
Detailed Description of Party's Property involved in this loss					
Detailed Description of the damage to the Party's Property involved in this loss					
Estimated Value of Damage					
Insurance Company					

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Policy Number					
When/Where Property Can Be Seen for Damage Assessment					
When can be seen					
Location Name					
Location Owner First and Last Name					
Street Address					
City		***State**		**Zip**	

Involved Party Information for Involved Party #2

First Name				**Middle Initial**	
Last Name				**Gender**	
Email Address					
Date of Birth		**Marital Status**		**Date of Death**	
Street Address					
City		**State**		**ZIP**	
Home Phone		**Work Phone**			

Work Details

Employer Name		**Employer Phone**	
Occupation		**Involvement Type**	

Injury Details

Type of Injury	
Part and Side of Body Injured	
Detailed Description of Injury	

Medical Treatment

Has the claimant already sought medical treatment?					
Hospital/ Clinic	**Location Name**				
	Street Address				
	City		***State**	**Zip**	
Physician/ Doctor/ Practitioner	**Location Name**				
	Street Address				
	City		***State**	**Zip**	

Detailed Description of Party's Property involved in this loss	
Detailed Description of the damage to the Party's Property involved in this loss	
Estimated Value of Damage	
Insurance Company	
Policy Number	
When/Where Property Can Be Seen for Damage Assessment	

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When can be seen					
Location Name					
Location Owner First and Last Name					
Street Address					
City		***State**		**Zip**	

Notes/Additional Comments (i.e., if this is for report only)	
Additional Remarks	

Additional Contact Information

Please list additional individuals who should receive a copy of this report of this loss.

First and Last Name	**Email Address**