INITIAL MEMBER CLAIM INTAKE FORM

MEMBER INFORMATION					
Location (State):					
County:					
Policy Number:					
Policy Inception Date:					
Primary Adjuster:					
LOSS INFORMATION					
Coverage Type:	***Select***				
Member Claim Number:					
Claimant Name (Last, First) Or Property Address/CAT #:					
Date of Loss (Occurrence Date):		Was a claim filed with the member or the county?	***Select***	If Yes, Date *Claim Filed:*	
Brief Claim Description:					
CRL Report Reasons:	☐ Exceeds 50% of Retention	☐ Bad Faith	☐ Sexual Assault/Molestation		
	☐ Amputation	☐ Class Action	☐ Cyber		
	☐ Burns	☐ Fatality	☐ Hearing/Vision Loss		
	☐ Multiple Fractures	☐ Nerve Damage	☐ Occupational Disease		
	☐ Paraplegia/Quadriplegia	☐ Injury to nerve at base of spinal canal or back Injury that results in incontinence of bowel and/or bladder	☐ Other		
	☐ Brain Injury	☐ Environmental	☐ Massive Internal Injuries		
Forms to be included:	☐ Declarations Page/ Memorandum of Coverage (MOC) **(Required)**	☐ First Report of Injury (WC only)	☐ Police Report or Scene Investigation	☐ Legal Fillings	
ADDITIONAL DATA **Provide additional data if available.**					
Employment Status (WC):		**Employment Date (WC):**			
Details regarding injury and body parts:					
Property Address(es):					
Additional information:					

Email the form and supporting documents to CRL.Claims@countyre.org

12/31/2024