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Arch Claim or Incident Reporting Form

Upon completion, please email or fax this form to Claims@ArchInsurance.com or 866.266.3630

Type of Claim/Line of Business (if known):

- ☐ Commercial General Liability
- ☐ Crime
- ☐ Cyber
- ☐ Directors and Officers
- ☐ Employment Practices Liability
- ☐ Fiduciary
- ☐ Healthcare
- ☐ Kidnap, Ransom and Extortion
- ☐ Property
- ☐ Professional Liability
- ☐ Third Party Administered Claims

Today's Date: *(mm/dd/yyyy)* _____ **Date of Loss**: *(mm/dd/yyyy)* _____

TO BE COMPLETED BY THE INSURED/INSURED'S REPRESENTATIVE:

Claim Form Completed By: _____

Relationship to Insured *(if applicable):* _____

Contact Information: _____*(phone)* _____ *(email)*

Description of Claim/Incident:

_____

Address of Claim/Incident *(including Zip Code):* _____

Insured's Name: _____ **Policy Number**: _____

Applicable Policy Period: _____

Mailing Address: _____

Phone Number: _____ (w) _____ (m) **Email**: _____

Insured's Contact Person: _____ **Preferred Method of Contact**: ☐ email ☐ phone

Phone Number: _____ (w) _____ (m) **Email**:_____

Is this related to a previously reported claim? ☐ YES ☐ NO

If YES, provide the information on the previously reported claim:

_____

Please identify under which Insuring Agreement(s) you are seeking coverage:

_____

Has an internal investigation been undertaken? ☐ YES ☐ NO

If YES, please provide all relevant information/findings:

_____

Is this a Demand Letter? ☐ YES ☐ NO

If so, what date did you receive the Demand Letter? *(mm/dd/yyyy)* _____

Is the claim in litigation? ☐ YES ☐ NO If so, what date was the Summons/Complaint received? _____
(mm/dd/yyyy)

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PLEASE PROVIDE IF APPLICABLE:

Name of Insured's Broker: _____ Preferred Method of Contact: ☐ email ☐ phone

Phone Number: _____ (w) _____ (m) Email: _____

Defense Counsel Firm Name and all Partners and Associates Assigned:

_____

Lead Partner Contact Information:

Phone Number: _____ (w) _____ (m) Email: _____

Partner/Associate/Paralegal Hourly Rates: _____

Was Other Insurance put on notice? ☐ YES ☐ NO

If YES, please attach a copy of the Other Insurance Policy and coverage position, and complete the following:

a. Date Other Insurance was put on notice: *(mm/dd/yyyy)* _____
b. Other Insurance Carrier Name: _____
c. Other Insurance Policy Type: _____
d. Policy Number: _____
e. Policy Period: _____
f. Policy Limit and Deductible/SIR: _____
g. Other Insurance Claims Handler's Contact Information: Phone Number: _____ (w) _____ (m) Email: _____

TO BE COMPLETED BY CLAIMANT OR THEIR COUNSEL:

Claimant's Name: _____ **Address**:_____

Phone: _____ **SS#:**_____ **DOB**: _____ **Occupation**: _____

Claimant's Attorney: _____

Address: _____

Phone Number: _____ (w) _____ (m) **Email**: _____

Description of Claim/Incident:

_____

Address of Claim/Incident (including Zip Code): _____

Current Status of Claim/Incident: _____

Please attach any and all claim related documents, investigative materials, claim communications, summons, complaints, any and all pleadings, and all referenced enclosures and/or attachments.