ASSOCIATION INSURANCE MANAGEMENT INC

# Claim Form

## Organization Information:

Name of Organization: _____

Insured Number: _____ Policy Number: _____

Address: _____ City, State & Zip: _____

Council: _____ District: _____

## Person Reporting Claim:

Name: _____ Position: _____

Phone Number: _____ Email Address: _____

## Type of Loss:

- ☐ Theft of money - Was a police report filed? ☐ Yes ☐ No If so, please include.
- ☐ Theft or Damage of property - Was a police report filed? ☐ Yes ☐ No If so, please include.
- ☐ Injury
- ☐ Other _____

## Witness Contact Information:

Witness Name: _____ Phone Number: _____

Email Address: _____

Witness Name: _____ Phone Number: _____

Email Address: _____

Witness Name: _____ Phone Number: _____

Email Address: _____

## Claim Occurrence:

Date of Occurrence: _____ Location: _____

Description of Occurrence: _____

_____

_____

_____

_____

_____

_____

## Injured Party Information:

Name: _____ Date of Birth: _____

Address: _____ City, State & Zip: _____

Phone Number: _____ Email Address: _____

Description of Injury: _____

_____

Cause of Accident: _____

_____

## Additional Information:

_____

_____

_____

**If you have any photos or videos of the event, please provide them.**

Please send completed Claim Form and any supporting documentation to:

**AIM Association Insurance Management, Inc.**
**PO Box 742946**
**Dallas, TX 75374**
**Phone: 800-876-4044 Fax: 214-360-0802**
**PTAClaims@aim-companies.com**

Edition 5/2018