701 – 305 Broadway, Winnipeg, MB, R3C 3J7

LIABILITY LOSS NOTICE

Broker Name:	Telephone:
Broker Contact:	Telephone:

DESCRIPTION OF LOSS

Date of Loss:	Type of Loss:
Time of Loss.:	Policy #:
Effective Date:	Expiry Date:
Insured Name:	Contact Person:
Tel (Cell):	Tel (Home):
Tel (Bus):	E-mail:
Insured Address:	
Location of Loss:	
Name of Person Reporting:	
Relationship to Insured:	
Details or circumstances that may result in a claim:	

Name of Claimant:
Address (if known):
Have you been served with a Writ of Summons or Statement of Claim? ☐ Yes ☐ No If 'Yes', please provide details:

To report a claim, please call 1-844-849-5099.
Please return completed form via email to newclaims@allmedunderwriting.com or fax to 204-925-8279