



Sedgwick Claims Kit





Dear Insured:

We would like to welcome you as a policyholder of Pacific Specialty Insurance. Sedgwick is your Claims Administrator and we are pleased to be able to provide you with our Property and General Liability claims handling services. Please follow the below instructions for filing a new claim and note the claim kit attachments.

Where do I report a claim?

- **Phone:** 855-728-5277 (855-7ATLAS7) OR;
- **Email:** 6200AtlasGeneralInsurance@sedgwickcms.com OR;
- **Fax:** 866-383-3296

Sedgwick Claim Kit Attachments:

- Claims Reporting Quick Reference Sheet
- General Liability Claim Intake Form

Need a loss run?

- **Email us:** Lossruns@atlas.us.com

Have more questions?

Contact the Atlas Customer Care Team at Sedgwick - One of our friendly Client Services Associates will be happy to assist you.

- **Phone:** 866-738-9201
- **Email:** AtlasTeam@Sedgwickcms.com

We appreciate your business and believe that communication is critical for successful claims administration. We encourage you to contact us if you have any questions.

www.Atlas.us.com/claims



Toll-free Claims Reporting Quick Reference Sheet for Property and General Liability Claims

1-855-728-5277

To report your property and general liability claims quickly and efficiently, please have the following information ready when you call our toll-free claims reporting service. This is a general listing for your quick reference. Additional information may be requested. Thank you for your prompt claims reporting!

CLIENT INFORMATION

- ~ **Insured Name and DBA ("doing business as" name)**

CLAIMANT INFORMATION

- ~ **Claimant Name**
- ~ **Claimant addresses and phone number**
- ~ **Any other information pertinent to the claim**

LOSS INFORMATION

- ~ **Exact date and time of the injury or damage**
- ~ **Exact location where injury or damage occurred**
- ~ **Specific description of injury or damage**
- ~ **Witnesses or Passengers - name, address, and phone numbers.**

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General Liability Intake Form

Client Name:		Contract Number:	
Reporter Information			
First Name:		Last Name:	
Title:	Phone:	Ext:	
Client Location Information			
Location Number:		Location Name:	
Street Address:			
City:	State:	Zip Code:	
Phone:		Ext:	
Is this the loss location? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Incident Information			
Date of Incident:		Time of Incident:	AM <input type="checkbox"/> PM <input type="checkbox"/>
Date Employer Notified:			
Incident Description:			
Incident Location Information (If different from above)			
Incident Location Name:			
Street Address:			
City:	State:	Zip Code:	
Authority Information			
Authority Name:		Phone:	Ext:
Authority Report Number:			
Property Information			
Property Description:			
Damage Description:			
Damage Estimate Amount:			
Owner Information			
Owner Type: Select One			
Name:			
Street Address:			
City:	State:	Zip Code:	
Phone:		Ext:	
Other Insurance Information			
Carrier:		Phone Number:	
Involved Party Information			
First Name:		MI:	Last Name:
Home Phone:			
Home Address:			
City:	State:	Zip Code:	
Date of Birth:		Gender: Select One	
Marital Status: Select One		Relationship to Client: Select One	
Injury Information			
Injury Description:			
Cause:		Body Part:	
Nature:			

Medical Treatment			
Admitted to Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Hospital / Clinic Name:			
Street Address:			
City:	State:	Zip Code:	
Phone:		Ext:	
Transportation Type: Select One			
Witness Information			
Name:			
Address:			
City:	State:	Zip Code:	
Phone:			
Contact Information			
First Name:	MI:	Last Name:	
Phone:	Ext:	Email Address:	
Comments/Remarks:			