

CPA EMPLOYER **GARD**[®]

AICPA Employment Practices Liability Insurance Program

Employment Practices Liability Insurance

Claim Report

Policy Number: _____

Policyholder's Name (*Named Insured as it appears on Declarations Page of the Policy*):

Policyholder's Address:

Policyholder's Location (if different from the above address):

Street Address

City

State

Zip

Contact Person:

Name

Title

Telephone Number (including Area Code)

Name of Person(s) Making Allegation(s) of Wrongful Act(s):

Name

Title

Name

Title

Name(s) of Insured(s) Who Allegedly Committed the Wrongful Act(s):

Name

Title

Name

Title

Names of any Witnesses to the Alleged Wrongful Act(s):

Name

Name

Date(s) the Wrongful Act(s) Allegedly took place:

Brief Description of the Claim:

Signature

Title

Date

*** When reporting a claim please submit any demands, notices, summonses, or legal papers received in connection with the claim:**

Please Mail or Fax your claim form and any accompanying documents to:

CNA
Employment Practices Liability
333 S. Wabash Avenue
Floor 39
Chicago, Illinois 60604
Facsimile: 866-419-6276

X-5421-609