The Insurance Carrier will need the following information to establish a claim. Please complete as much as possible.

Automobile Accident Claim Reporting Form

Office Use:
Client Code _____

Today's Date: _____ **Policy No.:** _____

Named Insured (Include DBA if applicable): _____

Mailing Address of Insured: _____

Contact Name: _____ Phone No.: _____

Email Address: _____

Date of Loss: _____ **Time of Loss**: _____

Insured Driver Name: _____ Driver Phone No.: _____

Insured Vehicle Involved (Year, Make & Model): _____
Insured Vehicle License Plate no.: _____

What happened: _____

_____

Describe Damage to the Insured Vehicle: _____

Location of Accident (Address or Cross Street, incl City & State): _____

Child car seat in the insured vehicle? ☐Yes ☐No

Any injuries? ☐Yes ☐No If so, Injured Name: _____

Phone No.: _____ Description/Extent of Injuries: _____

Were Emergency Services Rendered? ☐Yes ☐No Any Additional Injuries? ☐Yes ☐No

Is there a Police Report? ☐Yes ☐No Dept. Name:_____ Report No.: _____

Other Party: **Vehicle**: Year: _____ Make: _____ Model: _____

Driver Name: _____ Phone No.: _____

Address: _____

Registered Owner if different: Name: _____ Phone No.: _____ Address:_____

Additional Vehicles involved? ☐Yes ☐No

Other Vehicle Insurance Information (Carrier / Policy Number / Agent or Broker Name):

_____

Witness Information: Name: _____ Phone No.:_____

Address: _____

Witness Statement: _____

Reported By: _____ Phone No.: _____

Title: _____ Date: _____

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