

## AUTO CLAIM REPORTING FORM

Insured Name: \_\_\_\_\_

### AUTO CLAIM INFORMATION

Date of Accident: \_\_\_\_\_ Location of Accident: \_\_\_\_\_

Description of Accident: \_\_\_\_\_

\_\_\_\_\_

Authority Contacted: \_\_\_\_\_ Report #: \_\_\_\_\_

### INSURED VEHICLE INFORMATION

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_

VIN: \_\_\_\_\_ Estimated Damages: \_\_\_\_\_

Driver's Name: \_\_\_\_\_ Driver Contact Number: \_\_\_\_\_

Area of Damage: \_\_\_\_\_ Is Vehicle Drivable? \_\_\_\_\_

Where Can Vehicle be Seen? \_\_\_\_\_

Injured Party's Name/Describe Injury: \_\_\_\_\_

\_\_\_\_\_

Other Property Damage: \_\_\_\_\_

List Passengers: \_\_\_\_\_

### OTHER VEHICLE INFORMATION (IF KNOWN)

Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Vehicle Involved: \_\_\_\_\_

Injured Party's Name/Describe Injury: \_\_\_\_\_

\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

### WITNESS(ES)

Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Reported By: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Date: \_\_\_\_\_