AUTO CLAIM REPORTING FORM

OVD INSURANCE

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: _____

Employee: ☐ Owner/Operator: ☐

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: _____