

# Auto Claim



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

Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Will you be the direct contact for this claim? Yes  No

Claimant:  Our Insured:

Was anyone hurt? Yes  No

Who? \_\_\_\_\_

Extent of Injury - Details:

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Were the police called? Yes  No

If yes: Officer Name: \_\_\_\_\_ Badge #: \_\_\_\_\_

Department Information/Number: \_\_\_\_\_

Citation Issued: Yes  No  To Whom: \_\_\_\_\_

Case Number: \_\_\_\_\_

Any vehicles towed away from the accident? Yes  No

If yes, where?

Accident Details

Date/Time: \_\_\_\_\_

Location: \_\_\_\_\_

Extent of Injury - Details:

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Driver Vehicle Information:

Insured:

Driver Name: \_\_\_\_\_

License #: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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

(Make/Model/Yr)

Plate #: \_\_\_\_\_

VIN: \_\_\_\_\_

Insurance Info: \_\_\_\_\_

Claimant:

Driver Name: \_\_\_\_\_

License #: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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

(Make/Model/Yr)

Plate #: \_\_\_\_\_

VIN: \_\_\_\_\_

Insurance Info: \_\_\_\_\_

Witnesses? \_\_\_\_\_

Was the claim reported to the other insurance carrier? \_\_\_\_\_