

AUTOMOBILE CLAIM REPORT FORM

Date of Incident: _____ Time of Incident: _____ a.m./p.m.
Location of Accident: _____
Police Department: _____ Case Number: _____
Description of Accident: _____

INSURED VEHICLE (YOUR VEHICLE):

Year/Make/Model: _____
Driver Name: _____ Phone: _____
Vehicle Drivable?: _____ Vehicle Towed?: _____
Damage Description: _____

OTHER PARTY VEHICLE:

Year/Make/Model: _____ Plate: _____
Owner Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Vehicle Drivable?: _____ Vehicle Towed? Towed to Location: _____
Damage Description: _____
Insurance Carrier: _____

INJURIES:

Name: _____
Describe Injury: _____

WITNESS:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

CLAIM REPORT COMPLETED BY: _____ **Date** _____

FAX IMMEDIATELY TO: 541-385-3231