AUTOMOBILE CLAIM REPORT FORM

Policy #_____

Location: _____

Address: _____

Date of Incident: _____ Time of Incident: _____ a.m./p.m.

Police Department: _____ Case Number: _____

Location of Accident _____

Description of Accident: _____

INSURED VEHICLE:

Year/Make/Model: _____

Plate: _____ VIN: _____

Driver Name: _____ Telephone: _____

Driver License Number: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Damage Area: _____ Amount: _____

OTHER PARTY VEHICLE:

Year/Make/Model: _____ Plate: _____

Owner Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Damage Area: _____ Amount: _____

Insurance Carrier: _____

INJURIES:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Guest: Yes:_____ No:_____

Describe Injury: _____

WITNESS:

Name: _____

Address: _____

Telephone: _____

WITNESS:

Name: _____

Address: _____

Telephone: _____

Email REPORT to: **Claims@RiskPointins.com**

Any questions, call: **971-282-4304**

PLEASE PUT NAME OF POLICY HOLDER IN SUBJECT LINE OF EMAIL