

# 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**