Auto Accident Report Form

Date:__________

Company Name:____

Employee completing report/title:___________________________________

Employee Email Address:____

Date of Loss:_______________

Time:______________ ___AM ___PM

Location of accident (Including city):____

____

Police Dept. notified? ___Yes ___No

Case number assigned:____

Ticket issued? ___Yes ___No

Issued to:____

For: ____

Insured Vehicle (Include last 4 digits of VIN):____

Damage to insured vehicle:____

Insured driver:______________________________________

Phone:____

Address of driver:____

Other driver name:_______________________________

Phone:__________________________

Address:____

Other vehicle:____

Insured with:____

Damage to other vehicles:_______________________________________

Policy no.:____

Description of accident:____
____
____
____
____

Injured individuals:____

Phone:________________________

Injured individuals:____

Phone:________________________

Witnesses:____

Phone:_______________________

Witnesses:____

Phone:______________________

Thank you for completing the Auto Accident Report Form.

Please, Fax form to: 813-289-4561, ATTN: Claims Dept.