# AUTO CLAIMS FORM

Date reported _____ By Whom_____

Date of Loss_____ Time of loss_____ Carrier_____

Policy Number_____ Insured Name_____

Hm Ph _____ Work Ph_____ Cell Ph_____

Best Time to Contact and Where_____

_____

Description of Accident_____

_____

_____

Accident Location_____ Who Responded_____

Driver of Vehicle_____ Injuries/Type_____

Name of Hospital_____ Location of Vehicle_____

_____

Vehicle in Accident_____ Is it Drivable?_____

Des. of Damages _____ Rental needed _____

_____

Claimant Name/Address/Phone_____

Any Injuries/Type_____

Name of Hospital_____

Vehicle_____ Is the Vehicle Drivable?_____ Rental Needed_____

Location of Vehicle_____

Des. of Damages _____

Insurance Carrier/Policy Number/Claim Number/Phone Number/Agent_____

_____

Any Passengers/Witnesses_____

_____