Auto Accident Report Form

Keep In Your Glove Box

POLICY HOLDER	Name:____ Address:____	Policy #:____ Phone #:____
INSURED VEHICLE, DRIVER AND USE	Vehicle: Year ____Make: ____Serial #:____ Vehicle: Year ____Make: ____Serial #:____ Owner of Above Vehicle:____ Was equipment being operated about business of Insured:____ Name of Driver:____ Address:____ ____ Driver's License #: ____	Lic. #:____State:____ Lic. #:____State:____ Trailer:____ Other Insurance Available:____ ____ Phone #:____ Age:____ #of Hours on Duty:____
CARGO LOSS	Type of loss and commodity: ____ Current Location: ____	Bill of Lading Enclosed: No____ Yes ____
DETAILS OF ACCIDENT	Date: ____ 20____ Time: ____am/pm____ Place: ____ Police Report Made To: ____ Case Number: ____ City - Officer's Number: ____ Any Charge(s) Made: ____ What Charge(s):____	Weather Conditions____ Conditions of Road: ____ City or Town: ____ State: ____ Against Whom: ____
DAMAGE TO VEHICLE OF POLICY HOLDER	**COLLISION:** ____**FIRE:**____**THEFT:**____ Present location of Insured Vehicle? ____ Insured's Estimate of Damage: ____ Can Insured Complete Repairs? ____Were Temporary Repairs Made: ____	**OTHER:** ____ Truck: ____Tractor:____ Trailer: ____Bus:____ Amount: ____
DAMAGE TO PROPERTY OF OTHERS	Owner of Vehicle: ____ Address: ____ License #:____Phone____ Damage: ____ Insurance Company: ____ Owner of Vehicle: ____ Address: ____ License #:____Phone: ____ Damage: ____ Insurance Company: ____	Driver of Vehicle: ____ Year and Make of Vehicle:____ License # :____ Policy #:____ State: ____ Driver of Vehicle: ____ Year and Make of Vehicle: ____ License #: ____ Policy #: ____ State: ____

INJURED	(1)	(2)	(3)
	Name:____ Address:____ ____ Phone: ____Age:____ Injuries:____ Doctor:____ Hospital:____	Name:____ Address:____ ____ Phone: ____Age:____ Injuries:____ Doctor:____ Hospital:____	Name:____ Address:____ ____ Phone: ____Age:____ Injuries:____ Doctor:____ Hospital:____

OCCUPANTS OF INSURED VEHICLE

NAME:_______________________________________ ADDRESS:____ PHONE:________________

NAME:_______________________________________ ADDRESS:____ PHONE:________________

OCCUPANTS OF OTHER VEHICLE:

NAME:_______________________________________ ADDRESS:____ PHONE:________________

NAME:_______________________________________ ADDRESS:____ PHONE:________________

IMPORTANT: INDEPENDENT WITNESSES: (Include names of bystanders who saw accident, or heard any statements made)

NAME:_______________________________________ ADDRESS:____ PHONE:________________

NAME:_______________________________________ ADDRESS:____ PHONE:________________

NAME:_______________________________________ ADDRESS:____ PHONE:________________

THE ACCIDENT	POLICYHOLDER'S VEHICLE: SPEED: Before The Accident: ______________________________mph At Instant of Accident: ___________________________per hour LIGHTS:____ (ON - OFF - DIM - BRIGHT) Which Side of Road ______________Warning:_____________ Direction Traveled:____________________________________	OTHER VEHICLE: SPEED: Before The Accident: ______________________________mph At Instant of Accident: ___________________________per hour LIGHTS:____ (ON - OFF - DIM - BRIGHT) Which Side of Road ______________Warning:_____________ Direction Traveled:____________________________________

DRIVER'S STATEMENT OF HOW ACCIDENT OCCURRED:

What part of your vehicle and what part of other car were first in touch? ____

Whom do you consider is responsible?____

Date Signed: ____Signature of Driver:____

Date Reported:__________________ **How Reported**: Phone_____ Email_____ Fax ______Letter ______ In Person _______Time ______

Attach a diagram to further explain accident, show points of compass, name of streets, direction of cars and position of cars at instant of accident