

AUTO CLAIM FORM

Company: _____
Submitted By: _____

Date / Time of accident: _____ / _____ AM PM

Was anyone involved in the accident hurt? Yes No
If yes, explain how & which hospital they were taken to? _____

Location of accident (City/State): _____

Description of accident? _____

Do you have a Police Report? Yes No If yes, please fax to 239-542-0693
If no, complete the following:

Report # _____ Police Department: _____
Officer: _____

Which vehicle on policy was involved? Year _____ Make _____
Model _____ Vin # _____
Who was driving? _____
Any violations/citations issued? Yes No Describe _____

Others Drivers Info:

Name: _____ Telephone # _____
Year, Make, Model of Car _____
Vin# _____

Insurance Company: _____
Policy # _____
Any violations/citations issued? Yes No Describe _____