

AUTO CLAIM FORM

INSURED

NAME _____

ADDRESS _____

DATE OF LOSS _____ TIME _____

VEH. YEAR _____ MAKE/MODEL _____ DRIVER _____

LAST SIX DIGITS ON VIN# _____ DAMAGE _____

VEHICLE TOWED, WHERE? _____

DESCRIPTION

LOCATION _____

POLICE DEPT. _____ CASE# _____ VIOLATIONS _____

DESCRIPTION _____

CLAIMANT

NAME _____ VEH. TYPE _____

ADDRESS _____

DAYTIME PH# _____ DAMAGE _____

INSURANCE CO. _____ POLICY# _____

INJURED

NAME _____ ADDRESS _____ TYPE OF

INJURY _____

WITNESS/PASSENGERS _____

REPORTED BY _____