

CLAIM REPORT

DOL: _____ **TIME:** _____ **AM** **PM**

DATE REPORTED _____ BY _____ TO _____

INSURED _____ PHONE (____) _____

DRIVER _____ DOB _____ DL# _____

INSURED VEHICLE: YEAR _____ MAKE _____ VIN _____

INS. COMPANY _____ POLICY # _____

LOCATION _____

DETAILS _____

DAMAGE _____

CITATION _____

OTHER PARTY (S)

**ATTACH ADDITIONAL "OTHER PARTY (S)" INFO **

NAME _____ PHONE (____) _____

ADDRESS _____

INS. CO. _____ AGENT _____

PHONE (____) _____ POLICY # _____ CLAIM # _____

OTHER VEHICLE: YEAR _____ MAKE _____

DAMAGE _____

INJURIES: NAME _____ PHONE (____) _____

NAME _____ PHONE (____) _____

WITNESS(ES): NAME _____ PHONE (____) _____

NAME _____ PHONE (____) _____

AUTHORITY _____

OFFICER _____ REPORT # _____

Fax to: (425) 656-9052