

KEEP THIS DOCUMENT IN YOUR GLOVE COMPARTMENT

IF YOU HAVE AN ACCIDENT, use this form to record the facts about the accident, including names and address of all parties involved, and any witnesses to the accident. Give the completed form to your insurance agent or company, or provide the information by phone.

| | |
|---|---|
| DATE OF ACCIDENT AND TIME _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM | LOCATION OF ACCIDENT (INCLUDE CITY & STATE) |
|---|---|

DESCRIPTION OF ACCIDENT (USE REVERSE SIDE IF NECESSARY)

| | |
|----------------------------------|---|
| AUTHORITY CONTACTED AND REPORT # | ANY VIOLATIONS/CITATIONS AS A RESULT OF THE ACCIDENT (DESCRIBE) |
|----------------------------------|---|

PROPERTY DAMAGED (NOT YOUR VEHICLE)

| | | |
|--|--|---------------------------|
| DESCRIBE PROPERTY (If auto, year, make, model, plate #) | INSURANCE COMPANY | |
| OWNER'S NAME & ADDRESS | RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext): | |
| OTHER DRIVER'S NAME & ADDRESS (Check if same as owner) | RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext): | |
| DRIVER'S LICENSE NUMBER | DESCRIBE DAMAGE | WHERE CAN DAMAGE BE SEEN? |

INJURED PARTIES

| NAME & ADDRESS | PHONE (A/C, No) | AGE | DESCRIBE INJURY |
|---|-----------------|-----|-----------------|
| INJURED WAS: <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> IN YOUR CAR <input type="checkbox"/> IN OTHER CAR | | | |
| INJURED WAS: <input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> IN YOUR CAR <input type="checkbox"/> IN OTHER CAR | | | |

WITNESSES OR PASSENGERS

| NAME & ADDRESS | PHONE (A/C, No) | INS VEH | OTH VEH | OTHER (Specify) |
|----------------|-----------------|---------|---------|-----------------|
| | | | | |
| | | | | |

YOUR INSURED VEHICLE

| | | | | |
|---|---------------|-------------------------|--|-----------------------|
| YEAR | MAKE | MODEL | PLATE NUMBER | STATE |
| OWNER'S NAME & ADDRESS | | | RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext): | |
| DRIVER'S NAME & ADDRESS (Check if same as owner) | | | RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext): | |
| RELATION TO INSURED (Employee, family, etc.) | DATE OF BIRTH | DRIVER'S LICENSE NUMBER | STATE | PURPOSE OF USE |
| DESCRIBE DAMAGE | | | WHERE CAN VEHICLE BE SEEN? | WHEN CAN VEH BE SEEN? |
| YOUR INSURANCE COMPANY NAME | | YOUR POLICY NUMBER | YOUR AGENT'S NAME | |

POLICYHOLDER INFORMATION

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|-------------------------------|--|
| POLICYHOLDER'S NAME & ADDRESS | RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext): |
| REMARKS | |