AUTOMOBILE LOSS REPORT

NAME OF INSURED ______________________________

REPORT TO BE COMPLETED & GIVEN TO: ______________________________

DATE OF ACCIDENT: __________ TIME: ________ LOCATION: __________

YOUR VEHICLE (YR., MAKE): ______________ VEH ID#: __________

PRESENT LOCATION OF VEHICLE: ______________________________

OPERATOR OF YOUR VEHICLE: ____________ AGE: _____ ADDRESS: ________

DESCRIPTION OF ACCIDENT: ______________________________

____

____

OTHER VEH (YR.,MAKE): ______________ PLATE #: __________

OWNER: __________ ADDRESS: __________ PHONE #: __________

DRIVER: __________ ADDRESS: __________ PHONE #: __________

OTHER AGENT OR INS. CO.: ______________ PHONE #: __________

OTHER AGENT OR INS. CO. ADDRESS: ______________________________

AREA DAMAGED ON YOUR VEH: ______________ OTHER VEH: __________

INJURIES

NAME: ______________ NAME: ______________

ADDRESS: ______________ ADDRESS: ______________

AGE: ______ PHONE: __________ AGE: ______ PHONE: __________

INJURY: ______________ INJURY: ______________

WITNESSES

NAME: ______________ NAME: ______________

ADDRESS: ______________ ADDRESS: ______________

______________ ______________

POLICE DEPT: ______________ TICKETS ISSUED: __________

OTHER COMMENTS: ______________________________

REPORT COMPLETED BY: ______________________ DATE: __________

PERSON TO CONTACT ON THIS CLAIM: ______________ PHONE: __________