

AUTO CLAIM QUESTIONS

Insured Name: _____ Reported By: _____

Date of Loss: _____ Time of Accident: _____

Authority Contacted Type: _____

What Happened:

Where accident occurred:

Who was driving vehicle:

Name: _____

Date of Birth: _____

License #: _____ State: _____

Phone#: _____

Vehicle Year: _____ Make/Model: _____

VIN: _____

Type of damage to insured vehicle: _____

Was other vehicle involved: _____

Owner Name: _____

Owner Address: _____

Owner Phone #: _____

Driver Name: _____

Driver Address: _____

Driver Phone #: _____

Vehicle Year: _____ Make/Model: _____

Vehicle Insured with: _____

Type of damage to claimant vehicle: _____

Was anyone injured: _____

Who was injured: _____

What vehicle was injured party in: _____

Taken to hospital: _____

What hospital / location: _____

Any other property damaged: _____

What was damaged: _____

Owner Name: _____

Owner Address: _____

Phone #: _____