

AUTO INCIDENT FORM

Date Reported: _____

AM Initials: _____

Insured Name: _____

Insured Contact: _____

Insured Address: _____

Phone: _____

Police notified Y N

Police Department: _____

Date of loss: _____ Time: _____

Location of loss: _____

Description:

Insured Vehicle: Year _____ Make _____ Model _____ VIN _____

Insured Vehicle: Driver Name _____ Primary Phone _____

Describe Damage: _____

Estimate amount: _____ Where can vehicle be seen? _____

(Map to Property Damaged) Other Vehicle: Year _____ Make _____ Model _____

Other Vehicle: Driver Name _____ Phone: _____

Driver Same as Owner: Y N Owner Name: _____

Primary Phone: _____



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AUTO INCIDENT FORM

Damage Description:

Estimate: _____ Where can damage be seen? _____

Witness/Passenger: _____

Name/Address/Phone: _____

Injured:

Name/Address/Phone/Extent of Injury:

Property Damaged – Other than vehicle:

