

CLAIM REPORTING CHECKLIST

This form is designed to help you document all of the necessary facts in the unfortunate event that an employee has an accident with a company vehicle. We recommend that you place a copy of this form in each vehicle in your corporate fleet, after completing the Customer Information, Vehicle Information and Vehicle Operator sections.

CUSTOMER INFORMATION

Policy #: _____

Insured: _____

Address: _____

City/State/Zip: _____

Contact: _____

Contact Telephone: _____

Alternate Telephone: _____

Nature of Customer's Business: _____

Agent's Name: _____

Agent's Telephone: _____

VEHICLE INFORMATION

Make of Vehicle: _____ Year: _____

Serial # (VIN): _____

Registration/plate #: _____

If Fleet Vehicle, Operator's Name: _____

Vehicle Operator _____

Name: _____

Date of Birth: _____

Address: _____

License Number: _____

► NOTE: The vehicle operator should complete the rest of the form if they have an accident while driving a company vehicle.

Passenger(s)

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Name: _____

Address: _____

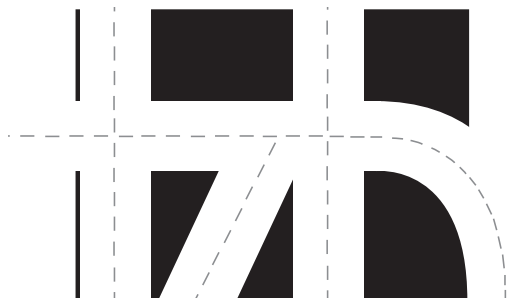
City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Diagram of Accident

Show street names and direction in which the vehicles were traveling. Indicate N, S, E & W.



Accident Information

Date Accident Occurred: _____ Hour: _____ a.m. / p.m.

Where Accident Occurred: _____

Rate of Speed: _____

How accident occurred: _____

CONTRIBUTING FACTORS: (Check all that apply)

Weather:

clear cloudy rain fog/smoke snow/sleet

Visibility:

daylight dawn dusk darkness road unlighted road lighted

Roadway:

dry concrete dirt/sand metal surface asphalt

muddy ice/snow gravel wet obstructions (list)

Road Characteristics:

- straight level grade business area residential area rural
- curve turn parking zone industrial area school zone

Type of Location:

- street alley crosswalk highway parking lot underpass
- bridge driveway loading dock intersection railroad crossing

Objects Involved:

- automobile bicycle brakes truck animal wipers
- train fixed object couplings bus pedestrian horn
- tires lights motorcycle tractor-trailer object in road
- other _____

Other Factors:

- speed right turn left turn overturned failure to yield
- steering U-turn stop sign engine failure traffic signal
- improper pass ran off road DWI drugs DWI alcohol
- in wrong lane drove left of center improper following

IMPORTANT! PHYSICAL DAMAGE INFORMATION

► Damage to Property/Vehicle of Others

Registered Owner: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Operator Name: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Car Year/Make/Model: _____

Vehicle Registration/Plate: _____

Insurance Company: _____

Policy Number: _____

Passenger Name: _____

Description of Damage: _____

► Passenger(s)

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

IN CASE OF AN ACCIDENT, FOLLOW THESE STEPS:

1. Stop at a safe distance from passing traffic! Investigate and determine damage.
2. Turn on warning flashers. Set up warning flares or reflectors if possible.
3. Help the injured. Get medical help if necessary.
4. Call the police. Notify local and/or state police as required.
5. Identify yourself to the parties involved. Give your name, address and driver's license information. Give registration information upon request.
6. Be courteous, but make NO statements about the accident except to the police
7. Obtain information to complete this report form. Be sure to get the other driver's name, address, license, vehicle information and insurance company name. Be sure to get the names and addresses of any passengers as well as any witnesses.
8. Report the accident as quickly as possible to your employer if the vehicle is part of a corporate fleet. They will notify the company's insurance agent

► Injured Persons

Name: _____

Address: _____

City/State/Zip: _____

Date of birth/age: _____

Telephone (home): _____

Telephone (work): _____

Nature of injuries: _____

Ambulance called: Y / N

Name of Doctor(s)/Hospital(s) Involved: _____

Name: _____

Address: _____

City/State/Zip: _____

Date of birth/age: _____

Telephone (home): _____

Telephone (work): _____

Nature of injuries: _____

Ambulance called: Y / N

Name of Doctor(s)/Hospital(s) Involved: _____

► Witnesses

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Their description of incident: _____

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Their description of incident: _____

Name: _____

Address: _____

City/State/Zip: _____

Telephone (home): _____

Telephone (work): _____

Their description of incident: _____
