CLAIMS DIRECT ACCESS INCIDENT FORMS

24 HOUR CLAIMS LINE 877.243.8182

ACTION PLAN FOR INCIDENTS

1. Call the Police
2. Do Not Admit Fault
3. Take 360° Video and Pictures
4. Fill out Attached Incident Forms
5. Call Us Immediately 877.243.8182

CLAIMS™
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INCIDENT REPORTING FORM

General Information

Insured (Policy Holder): _____ Policy Number: _____

Contact Name: _____ Phone number: ( ) _____

Address: _____

City: _____ State _____ Zip: _____

Loss Information

Date of Accident: _____ Time of Day: _____ o AM or o PM

Address of Accident (include city and state): Street Address: _____

_____

City: _____ State: _____

Passenger(s): o Yes or o No (Please note name and contact information on additional page)

Injuries: o Yes or o No (Please note name and contact information on additional page)

Police or Fire Department to which you reported: _____

Report, Case or File Number: _____ (Enclose a copy if available)

Violations or Citations issued: _____

Property Damage to the Insured's Vehicle

Year: _____ Make: _____ Model: _____ Body Type: _____

Vehicle Identification Number (VIN): _____ Cab No. _____

Driver's Name: _____ Phone Number: ( ) _____

Driver's Address: _____

Driver's License Number: _____ State Issued: _____ Birthdate: _____

Purpose of Vehicle Use: _____ Used with Permission? o Yes o No

Describe Damage: _____

_____

Where is the vehicle now? _____

Other Vehicle Information

Owner's Name: _____ Phone Number: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Year: _____ Make: _____ Model: _____ Body Type: _____

Vehicle Identification Number (VIN): _____

Insurance Co. _____ Policy No. _____

Driver's Name (if different from owner): _____

Driver's Phone Number: ( ) _____ License No. _____

Damage/Estimate: _____

Details of Damage: _____

1. Names of Witnesses or Passengers and their remarks. (Use reverse side if necessary).

   Passenger/Witness #1: _____ Telephone Number: ( )_____

   Address: _____

   Remarks: _____

   Passenger/Witness #2: _____ Telephone Number: ( )_____

   Address: _____

   Remarks: _____

2. Injured.

   1) Name: _____ Telephone Number: ( ) _____

   Address: _____

   Description of Injury: _____

   2) Name: _____ Telephone Number: ( ) _____

   Address: _____

   Description of Injury: _____

Description of Accident (Drivers Statement): _____

_____

_____

_____

_____

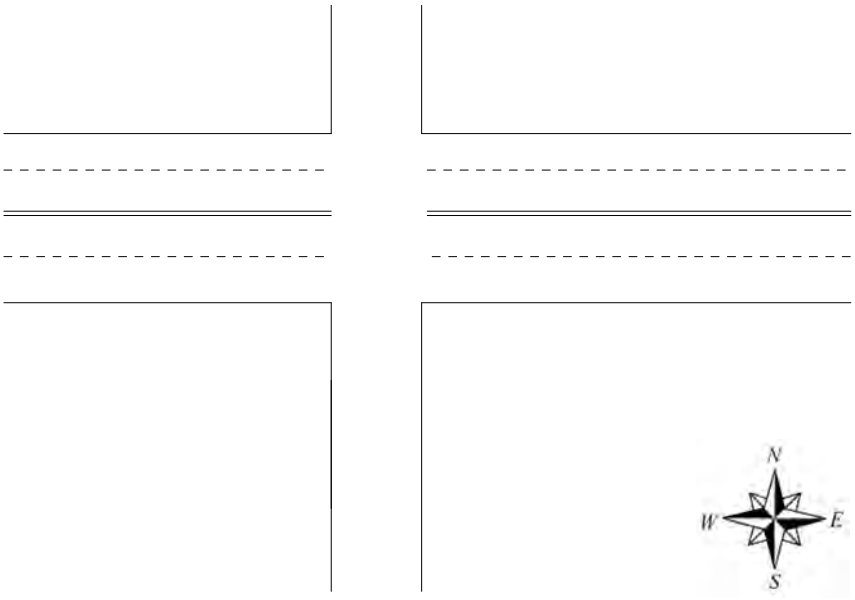
_____

_____

_____

Signature: _____ Title: _____

Print Name: _____ Date: _____



CLAIMS DIRECT ACCESS™

WITNESS STATEMENT FORM

Our insurance company asks us to collect witness statements pertaining to accidents so they may determine how these accidents occur. Please provide the information requested below as completely as possible. Thank you for your assistance in this very important matter.

Name of Insured: _____ **Policy No.**_____

Your Name: _____

Address: _____

Phone: _____ Email: _____

1. Please describe events leading up to the accident.

_____

_____

_____

2. Please describe the accident

_____

_____

_____

_____

3. Describe what happened after the accident took place.

_____

_____

_____

4. Can you think of any way this type of accident could be avoided in the future?

_____

_____

_____

5. Were sufficient warnings, instructions, and information provided?

_____

_____

_____

Signature: _____ Date: _____

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Signature: _____ Date: _____