

# Automobile Accident Information

Please Print Clearly, this information is needed to properly process your claim.



Print Your Name \_\_\_\_\_

Date & Time of Accident \_\_\_\_\_ Accident Occurred in State of \_\_\_\_\_

Specific Location of Accident - Town & Street \_\_\_\_\_

Describe the accident in detail. Include where the vehicle was hit, from what direction and how much damage occurred.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the driver? Yes  No  If "No", who was? \_\_\_\_\_

Was it your vehicle? Yes  No  If "No", whose car was it? \_\_\_\_\_

What type of vehicle were you in? Car  SUV  Pickup Truck  Other  \_\_\_\_\_

What type of vehicle were you hit by? Car  SUV  Pickup Truck  Other  \_\_\_\_\_

Were you charged with the accident? Yes  No  If "No", who was? \_\_\_\_\_

Did you go to the hospital immediately? Yes  No  If "Yes", where? \_\_\_\_\_

Were you wearing seat belts? Yes  No  Were you knocked unconscious? Yes  No

Have you ever had a previous accident that caused you to see a doctor? Yes  No  If "Yes", explain below.

\_\_\_\_\_

Do you have automobile accident insurance? Yes  No  If "Yes", give name & contact information of company.

\_\_\_\_\_

Did you report the accident to your insurance company? Yes  No  If "Yes", when? \_\_\_\_\_

Did you get a police report? Yes  No  If "Yes", please give us a copy.

Do you have any other group or health insurance? Yes  No  If "Yes", provide information below.

\_\_\_\_\_

Have you retained an attorney? Yes  No  If "Yes", please give name and phone number below.

\_\_\_\_\_

Today's Date \_\_\_\_\_ **Your Signature Please** \_\_\_\_\_