



**Insurance Accident/Incident Report Form**

Name of Person Completing Form: \_\_\_\_\_

Vehicle Accidents/Incidents: \_\_\_\_\_

Time and Date of Accident/Incident: \_\_\_\_\_

Vehicle Description: \_\_\_\_\_

Location of Accident/Incident: \_\_\_\_\_

License Plate #: \_\_\_\_\_

Name, address and phone # of witnesses (if any)  
1 \_\_\_\_\_  
2 \_\_\_\_\_

Vehicle ID Number \_\_\_\_\_

Description: (be as detailed as possible, with facts, time of day etc)

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

Name, Address & Phone of Injured Parties:

1 \_\_\_\_\_  
2 \_\_\_\_\_

3 \_\_\_\_\_  
4 \_\_\_\_\_

Yes No

Were Police Called? yes/no

Police Dept: \_\_\_\_\_

Report #: \_\_\_\_\_

Insurance Information of Other Party: Policy # \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_

Company \_\_\_\_\_

*I certify that the above information is true and I have not willingly withheld any information.*

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)