ACCIDENT REPORTING FORM

CALL YOUR AGENT TO REPORT YOUR LOSS

ACCIDENT INFORMATION

DATE: _____ TIME: _____

#VEHICLES INVOLVED: _____

LOCATION: _____

TOWN: _____ STATE: _____

YOUR VEHICLE: _____

NAME OF INSURED OPERATOR: _____

RELATION TO INSURED: _____

OPERATOR ADDRESS: _____

OPERATOR CITY/STATE: _____ ZIP: _____

OPERATOR PHONE NO.: ( ) _____

PEDESTRIAN

NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

INSURANCE AGENT: Fitts Insurance Agency

PHONE #: 888-697-6542

OTHER VEHICLE INFORMATION

OWNER: _____

ADDRESS (owner): _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

NAME OF OPERATOR OF OTHER VEHICLE: _____

RELATION TO OWNER: _____

DRIVER'S LICENSE #: _____

EXP. DATE: _____

PLATE REGISTRATION: _____

STATE: _____ EXP: _____

YEAR OF VEHICLE: _____ MAKE: _____

MODEL: _____

INSURANCE COMPANY: _____

WITNESSES

1) NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

2) NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

PLEASE PROVIDE THE FOLLOWING WHEN YOU CONTACT THE CLAIM OFFICE:

- **Your Operator Name, License # & Date of Birth**
- **Your Vehicle Year, Make & Registration**
- **Your Policy #**

INJURIES

1) NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

DESCRIPTION OF INJURIES: _____

LOCATION OF INJURED PARTY: Your Vehicle ☐ Other Vehicle ☐

2) NAME: _____

ADDRESS: _____

CITY/STATE: _____ ZIP: _____

PHONE NO.: ( ) _____

DESCRIPTION OF INJURIES: _____

LOCATION OF INJURED PARTY: Your Vehicle ☐ Other Vehicle ☐