



Name of Person Reporting: _____ Telephone: _____

ADDRESS INFORMATION

Name of the Company: _____

Address of the Company: _____

Contact Name: _____

Telephone Number of Loss Location: _____

Site Code (if applicable): _____

ACCIDENT INFORMATION

Date and Time of Accident: ___/___/___ _____ am pm

Address where Accident Occurred: _____

Description of the Incident:

Were Authorities Contacted? (i.e. Police, Fire, Ambulance) Yes No

If Yes, who? _____

Was a Report Number given? Yes No

If Yes, list number: _____

Officer's Name: _____ Officer's Badge Number: _____



ACCIDENT INFORMATION (continued)

Were Citations Issued? Yes No

If Yes, to Whom and For What Violation: _____

Were any Safeguards provided? Yes No Were they in use at the Time of the Accident? Yes No

In the event of a Fatality, what is your OSHA number? _____

INSURED VEHICLE

Name of the Driver: _____

Address of the Driver: _____

Home Telephone Number: _____ Work Telephone Number: _____

Social Security Number: _____ Date of Birth: ____/____/____

Driver's License Number/State of Issue: _____

Name of the Owner: _____

Address of the Owner: _____

Home Telephone Number: _____ Work Telephone Number: _____

Name of the Leasor: (if not owned) _____

Address of the Leasor: _____

Vehicle Make: _____ Vehicle Model and Year: _____

VIN Number: _____ License Plate Number and State of Issue: _____

Current Location of Vehicle (address): _____



ALLIED NORTH AMERICA

AUTOMOBILE
FIRST REPORT OF CLAIM

Location Telephone Number: _____

Area of Damage: _____ Estimate: _____

Description of Damage:

Current Status of Vehicle? Drivable Towed from Accident Scene

Were any injuries in this vehicle? Yes No

Name of the Injured Party: _____ Telephone Number: _____

Address of the Injured Party: _____

Nature of Injury:

Name of Medical Provider: _____ Telephone Number: _____

Address of Medical Provider: _____

Name of Doctor: _____

Medical Attention Given:

CLAIMANT INFORMATION - OTHER VEHICLE

Name of the Driver: _____

Address of the Driver: _____



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FIRST REPORT OF CLAIM

CLAIMANT INFORMATION - OTHER VEHICLE (continued)

Home Telephone Number: _____ Work Telephone Number: _____

Social Security Number: _____ Date of Birth: ____/____/____

Driver's License Number/State of Issue: _____

Covered by Other insurance: Yes No If Yes, Company Name: _____

Contact Name: _____ Telephone Number: _____

Name of the Owner: _____

Address of the Owner: _____

Home Telephone Number: _____ Work Telephone Number: _____

Name of the Leasor: (if not owned) _____

Address of the Leasor: _____

Vehicle Make: _____ Vehicle Model and Year: _____

VIN Number: _____ License Plate Number and State of Issue: _____

Current Location of Vehicle (address): _____

Location Telephone Number: _____

Area of Damage: _____ Estimate: _____

Description of Damage

Current Status of Vehicle? Drivable Towed from Accident Scene



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FIRST REPORT OF CLAIM

CLAIMANT INFORMATION - OTHER VEHICLE (continued)

Were any injuries in this vehicle? Yes No

Name of the Injured Party: _____ Telephone Number: _____

Address of the Injured Party: _____

Nature of Injury:

Name of Medical Provider: _____ Telephone Number: _____

Address of Medical Provider: _____

Name of Doctor: _____

Medical Attention Given:

Please attach any additional vehicles and claimants to the back of this form.

PROPERTY INFORMATION - OTHER THAN VEHICLE

Description of the Property:

Address where the property is located: _____

Serial Number: _____ Estimate of Damage: \$ _____

Was business curtailed? Yes No

Was there consequential damage? Yes No



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FIRST REPORT OF CLAIM

CARRIER INFORMATION

Name of Carrier: _____

Policy Number: _____ Policy Inception/Expiration: _____

Write or type below anything related to the incident you would like to add.