

**ACCIDENT FACT SHEET**

Date: \_\_\_\_\_ Date of Loss: \_\_\_\_\_

Referred By: \_\_\_\_\_

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

How long employed: \_\_\_\_\_ Salary: \_\_\_\_\_

Any previous claims? \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Nearest Relative: \_\_\_\_\_

Relation Client: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**ACCIDENT INFORMATION**

**VEHICLE #1**

**(VEHICLE CLIENT WAS IN)**

Driver: \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

Passenger #1: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_

Passenger #2: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_

Passenger #3: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_

Make, model, and year of car: \_\_\_\_\_ Seat belts in use? \_\_\_\_\_

Value of car: \_\_\_\_\_ Location of car now: \_\_\_\_\_

Purchase date and price: \_\_\_\_\_ Lien and amount: \_\_\_\_\_

Damage done to your car: \_\_\_\_\_

**VEHICLE #2**  
**(GET SEPARATE INFORMATION FOR EACH VEHICLE INVOLVED)**

Driver: \_\_\_\_\_ License Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)  
Passenger #1: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_  
Passenger #2: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_  
Passenger #3: \_\_\_\_\_ Phone # \_\_\_\_\_ Where in Car? \_\_\_\_\_  
Make, model, and year of car: \_\_\_\_\_  
How did the accident happen? \_\_\_\_\_  
\_\_\_\_\_  
Damage done to their car: \_\_\_\_\_  
Other important information: \_\_\_\_\_  
Location of Accident (street, city, county): \_\_\_\_\_  
Any traffic signs or signals? \_\_\_\_\_ Anything obstructing view of either driver? \_\_\_\_\_  
Which police called to scene? \_\_\_\_\_  
Anyone drinking alcoholic beverages? \_\_\_\_\_ Drugs or medication? \_\_\_\_\_  
Any vehicles searched for same? \_\_\_\_\_ Anything suspicious found? \_\_\_\_\_  
Anyone chared with traffic violation? \_\_\_\_\_ Who? \_\_\_\_\_  
What wa the charge? \_\_\_\_\_ Police report filed? \_\_\_\_\_  
Pictures taken? \_\_\_\_\_  
Witnesses to this accident: \_\_\_\_\_  
Any other information you feel may assist us in representing you for this claim?  
\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE INFORMATION**  
**VEHICLE #1**  
**(VEHICLE CLIENT WAS IN)**

Insurance Co: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Policy holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Adjuster's name: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Address: \_\_\_\_\_

**COVERAGE LIMITS**

Any PIP or med-pay? \_\_\_\_\_ Other medical insurance? \_\_\_\_\_  
Property damage? \_\_\_\_\_ Uninsured motorists? \_\_\_\_\_  
Underinsured motorists? \_\_\_\_\_ FR-10 turned in? \_\_\_\_\_  
Has your insurance company been notified of this claim? \_\_\_\_\_

**VEHICLE #2  
(OTHER VEHICLE)**

Insurance Co: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Policy holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Adjuster's name: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Address: \_\_\_\_\_

**COVERAGE LIMITS**

Property damage? \_\_\_\_\_ Uninsured motorists? \_\_\_\_\_  
Underinsured motorists? \_\_\_\_\_ Any passengers in the car? \_\_\_\_\_  
Description of negligent driver: \_\_\_\_\_ Negligent driver's license #: \_\_\_\_\_

**CLIENT'S VEHICLE  
(IF PASSENGER)**

Insurance Co: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Policy holder: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Adjuster's name: \_\_\_\_\_ Claim Number: \_\_\_\_\_  
Address: \_\_\_\_\_

**COVERAGE LIMITS**

Any PIP or med-pay? \_\_\_\_\_ Property damage? \_\_\_\_\_  
Uninsured motorists? \_\_\_\_\_ Underinsured motorists? \_\_\_\_\_

**MEDICAL INFORMATION**

Head to toe complaint list: \_\_\_\_\_  
\_\_\_\_\_  
ER? \_\_\_\_\_ Ambulance (who)? \_\_\_\_\_  
Other hospitalization? \_\_\_\_\_  
Admitted? \_\_\_\_\_ Xrays taken? \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Names of Doctors treating you for this accident: \_\_\_\_\_  
\_\_\_\_\_

**HEALTH INSURANCE  
(INCLUDING MEDICARE OR MEDICAID)**

Insurance Co: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Insured: \_\_\_\_\_ Group Policy Number: \_\_\_\_\_  
Subrogation rights: Yes \_\_\_\_\_ No \_\_\_\_\_ Collector: \_\_\_\_\_  
Bills filed with health insurance company? \_\_\_\_\_  
Other important information: \_\_\_\_\_  
\_\_\_\_\_

**LOSS OF WAGES**

Employment at time of accident: \_\_\_\_\_ How long? \_\_\_\_\_  
Weekly hours: \_\_\_\_\_ Hourly wage: \$ \_\_\_\_\_ OT per week: \_\_\_\_\_ OT rate: \$ \_\_\_\_\_  
Time lost from work due to accident: \_\_\_\_\_

**PROPERTY DAMAGE**

Repair estimates: \_\_\_\_\_ Vehicle's present location: \_\_\_\_\_  
Other important information: \_\_\_\_\_  
\_\_\_\_\_