

Auto Claim Report

YOUR COMPANY NAME:			
YOUR CONTACT INFORMATION:			
Name:		Address:	
Phone:		E-mail:	Fax:
YOUR VEHICLE:			
Driver:		Phone:	
Year:	Make:	Model:	
VIN# (required):			
Describe Damage:			
OTHER VEHICLE:			
Driver:		Driver's Lic #:	State:
Owner:		Phone:	
Address:			
Year:	Make:	Model:	
License Plate #:			
Insurance Company:		Policy #:	
Describe Damage:			
ACCIDENT DETAILS:			
Date of Accident:		Time:	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Location:			
City:			
Tell In Your Own Way What Happened:			
INJURED PERSON:			
Name:		Phone:	
Check One: <input type="checkbox"/> Your Vehicle <input type="checkbox"/> Other Vehicle			
Describe Injuries:			
Name:		Phone:	
Check One: <input type="checkbox"/> Your Vehicle <input type="checkbox"/> Other Vehicle			
Describe Injuries:			
WITNESS & POLICE:			
Name:		Phone:	
Name:		Phone:	
Police Department:		Report #:	
Reported by:		Today's Date:	

Return this form to Arthur J. Gallagher when completed:

Fax: 415-536-4036
Phone: 415-546-9300
E-mail: claims-sf@ajg.com
Mail: 1255 Battery St., #450, San Francisco, CA 94111

