

AUTOMOBILE ACCIDENT REPORT FORM

Please submit this form to M3 Insurance Solutions for Business at
Fax: (608) 273-1725 E-mail: info@m3ins.com

Company Name & Address: _____

Telephone: _____ Date: ____/____/____

Employee Completing Report/Title: _____

DATE OF LOSS: ____/____/____ Time: _____ AM/PM

Location of Accident (including city): _____

POLICE DEPT. NOTIFIED? Yes No If yes, which police department? _____

Case Number Assigned: _____

Tickets Issued? Yes No Issued to: _____ For: _____

INSURED VEHICLE: _____
(Include last 4 digits of vehicle identification number)

Damage to insured vehicle: _____

INSURED DRIVER: _____ Phone: (____) ____ - _____

Address of Driver: _____

OTHER DRIVER NAME: _____ Phone: (____) ____ - _____

Address: _____

Other Vehicle: _____ Insured with: _____

Damage to Other Vehicle: _____ Policy No.: _____

DESCRIPTION OF ACCIDENT: _____

INJURED INDIVIDUALS: _____ Phone: (____) ____ - _____

_____ Phone: (____) ____ - _____

WITNESSES: _____ Phone: (____) ____ - _____

_____ Phone: (____) ____ - _____