AUTO CLAIM FORM

Insured/Moving Company:	
Reported by:	
Date Reported:	

LOSS INFORMATION

Date of Loss:			
Location of Loss:			
Police Department Involved:			
Ticket Issued:	☐ Yes ☐ No	Violation:	
Description of Accident:			

INSURED/MOVING COMPANY VEHICLE

Year:	Make:	Model:
VIN:		Plate:
Description of Damages:		
Driver:		
DL # & State:		

OTHER VEHICLE

Year:	Make:	Model:
VIN:		Plate:
Description of Damages:		
Owner of Vehicle:		
Owner's Phone Number:		
Owner Address:		
Insurance Company:		
Policy #:		

WITNESS

Name:	
Phone Number:	
Address:	

If there is a chance of injury or fatality or if this is a DOT reportable accident that requires a Drug and Alcohol test, contact John Vink ASAP at jvink@aegis-online.com or (989) 443-3886.