



AUTOMOBILE CLAIM REPORT FORM

Policy # _____

Location: _____
Address: _____
Date of Incident: _____ Time of Incident: _____ a.m. p.m.
Police Department: _____ Case Number: _____
Location of Accident: _____
Description of Accident: _____

INSURED VEHICLE:

Year/Make/Model: _____
Plate: _____ VIN: _____
Driver Name: _____ Telephone: _____
Driver License Number: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Damage Area: _____ Amount: _____

OTHER PARTY VEHICLE:

Year/Make/Model: _____ Plate: _____
Owner Name: _____ Telephone: _____
Address: _____ City: _____ State: _____ Zip: _____
Damage Area: _____ Amount: _____
Insurance Carrier: _____

INJURIES:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Guest: Yes: _____ No: _____
Describe Injury: _____

WITNESS:

Name: _____
Address: _____
Telephone: _____

WITNESS:

Name: _____
Address: _____
Telephone: _____

Email REPORT to: claims@riskpointins.com
Any questions, call: **971-282-4304**

PLEASE PUT NAME OF POLICY HOLDER IN SUBJECT LINE OF EMAIL