RISKPOINT
INSURANCE ADVISORS

AUTOMOBILE CLAIM REPORT FORM

Policy #_____

Location of Accident: _____

Address: _____

Date of Accident: _____ Time of Incident: _____ a.m p.m.

Responding Case Number: _____

Police Department: _____

Location of Accident _____

Description of Accident: _____

INSURED VEHICLE:

Year/Make/Model: _____ Owner: _____

Plate: _____ VIN: _____

Driver Name: _____ Telephone: _____

Driver License Number: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Damage Area: _____

OTHER PARTY VEHICLE:

Year/Make/Model: _____ Plate: _____

Owner Name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Damage Area: _____

Insurance Carrier: _____ Policy Number: _____

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