Auto Loss Report

Insured: _____ Contact Person: _____

Date of the Accident: ___/___/_____ Time Accident Occurred: _____
Contact Number: Home (____)_____ Work (____)_____

► **Accident Location:**
Address: _____
City:_____ State: _____ Zip: _____

► **Description of the Accident:**
Authority Contacted: _____Violations Cited'?⊙Yes ○No Report Case: #_____
Insured Vehicle: Year_____ Make_____ Model_____ VIN#: _____
Driver's Name: D.O.B. ___/___/_____
Describe the Damage:
_____
_____
_____

Estimated loss amount: $_____ When & Where the vehicle is being seen:

► **Property Damage to Other Auto**
Driver's Name: _____ Home *(____)* _____ *Work:* (____) _____
Address: City_____ State_____ Zip _____
Insurance Company: _____ Policy# _____
Owner's Name (if different): _____ Home *(____)* _____ Work: (____) _____
Address: City_____ State_____ Zip _____
Other Vehicle: Year_____ Make_____ Model_____ VIN#: _____
Describe the Damage to Other Auto:
_____
_____
_____

Estimated loss amount: $_____ When & Where the vehicle is being seen: _____

► **Injuries**

NAME & ADDRESS	PHONE	EXTENT OF INJURIES
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

► **Witnesses**
Name: _____ Phone_____ Name: _____ Phone_____
Additional Remarks: _____
_____

Reported By: _____

Fax or email this document to The Jacobs Company, Inc.
claims@jacobscompany.com
Fax # (301) 621-3043 **or** (410) 381-2105
www.jacobscompany.com