Sample of Accident Card (in English)

Front Side

ACCIDENT REPORTING FORM: CALL YOUR AGENT TO REPORT YOUR LOSS

INSURANCE AGENT: ____________________

PHONE #: ____________________

ACCIDENT INFORMATION

DATE: __________ TIME: __________
VEHICLES INVOLVED: __________
LOCATION: __________
TOWN: __________ STATE: __________
YOUR VEHICLE: __________
NAME OF INSURED OPERATOR: __________
RELATION TO INSURED: __________
OPERATOR ADDRESS: __________
OPERATOR CITY/STATE: __________ ZIP: __________
OPERATOR PHONE #: ( ) __________

PEDESTRIAN INFORMATION

NAME: __________
ADDRESS: __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________

OTHER VEHICLE INFORMATION

OWNER: __________
ADDRESS (OWNER): __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________
NAME OF OPERATOR OF OTHER VEHICLE: __________
____
RELATION TO OWNER: __________
DRIVER'S LICENSE #: __________
EXP. DATE: __________
PLATE REGISTRATION: __________
STATE: __________ EXP: __________
YEAR OF VEHICLE: __________ MAKE: __________
MODEL: __________
INSURANCE COMPANY: __________

Back Side

WITNESSES

1) NAME: __________
ADDRESS: __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________

2) NAME: __________
ADDRESS: __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________

PLEASE PROVIDE THE FOLLOWING WHEN YOU CONTACT THE CLAIM OFFICE:

- **Your Operator Name, License # & Date of Birth**
- **Your Vehicle Year, Make & Registration**
- **Your Policy #**

INJURIES

1) NAME: __________
ADDRESS: __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________
DESCRIPTION OF INJURIES: __________
____
LOCATION OF INJURED PARTY: YOUR VEHICLE ☐ OTHER VEHICLE ☐

2) NAME: __________
ADDRESS: __________
CITY/STATE: __________ ZIP: __________
PHONE #: ( ) __________
DESCRIPTION OF INJURIES: __________
____
LOCATION OF INJURED PARTY: YOUR VEHICLE ☐ OTHER VEHICLE ☐