

Risk Management Office
P.O. Box 369
Ogdensburg, NY 13669

Immediately after an accident fill out this form and send to:

LOCATION CODE
THIS ACCIDENT RESULTED IN: <input type="checkbox"/> BODILY INJURY <input type="checkbox"/> PROPERTY DAMAGE ONLY

ACCIDENT REPORT, AUTO AND TRUCK
(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

CLIENT					
NAME	PHONE	DRIVER NAME		PHONE	DATE OF BIRTH
ADDRESS			ADDRESS		NUMBER OF YEARS WITH COMPANY
CITY	STATE	ZIP	CITY	STATE	ZIP
					DRIVER'S LICENSE NO.

VEHICLE					
MAKE OF YOUR VEHICLE	YEAR	MODEL	SERIAL NUMBER	LICENSE NUMBER	WHERE VEHICLE CAN BE SEEN
TRAILER (IF APPLICABLE)	YEAR	MODEL	AREA OF DAMAGE	USED FOR BUSINESS <input type="checkbox"/> YES <input type="checkbox"/> NO	ESTIMATED COST TO REPAIR \$

ACCIDENT					
DATE OF LOSS	TIME OF LOSS	LOCATION (STREET OR HIGHWAY)		CITY	STATE
WERE POLICE CALLED TO SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO		POLICE DEPT. CALLED	DRIVER	ARRESTED	TICKETED
NAME OF OFFICER		BADGE NUMBER			
STATION ADDRESS					

CLAIMANT 1								
OWNER OF OTHER VEHICLE		AGE	ADDRESS		CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE		AGE	ADDRESS		CITY	STATE	ZIP	PHONE
MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE \$	WHERE CAN VEHICLE BE SEEN		

CLAIMANT 2								
OWNER OF OTHER VEHICLE		AGE	ADDRESS		CITY	STATE	ZIP	PHONE
DRIVER, IF OTHER THAN ABOVE		AGE	ADDRESS		CITY	STATE	ZIP	PHONE
MAKE OF VEHICLE	YEAR	MODEL	LICENSE NO.	AREA OF DAMAGE	ESTIMATE OF DAMAGE \$	WHERE CAN VEHICLE BE SEEN		

PROPERTY DAMAGE—OTHER THAN AUTO (ie. FENCE, CANOPY)					
OWNER OF PROPERTY		ADDRESS		CITY	STATE
DESCRIBE DAMAGED PROPERTY		LOCATION OF PROPERTY		CITY	STATE
					EXTENT OF DAMAGE

WITNESS INFORMATION					
NAME		ADDRESS		CITY	STATE
					ZIP
					PHONE
NAME		ADDRESS		CITY	STATE
					ZIP
					PHONE

NOTE: PLEASE COMPLETE REVERSE SIDE

PERSONS INJURED

(USE ADDITIONAL SHEET IF NECESSARY)

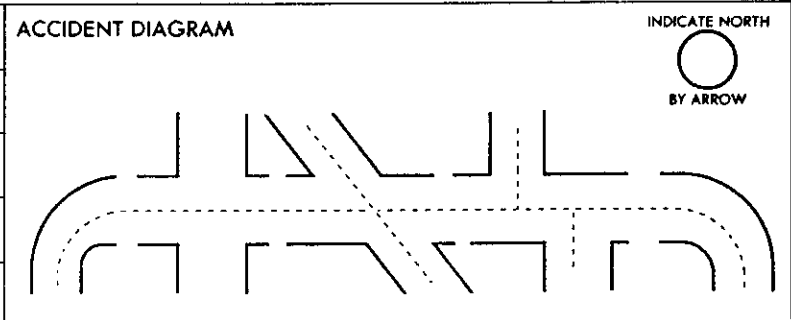
NAME	AGE	NAME	AGE
ADDRESS	PHONE	ADDRESS	PHONE
CITY	STATE	ZIP	CITY
STATE	ZIP	STATE	ZIP
OCCUPATION	WHERE TAKEN	OCCUPATION	WHERE TAKEN
<input type="checkbox"/> FATALITY <input type="checkbox"/> BLEEDING OR DISTORTED WOUND <input type="checkbox"/> UNCONSCIOUSNESS <input type="checkbox"/> NO VISIBLE INJURY — COMPLAINED OF PAIN <input type="checkbox"/> OTHER _____	<input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> IN YOUR VEHICLE <input type="checkbox"/> IN CLAIMANT VEHICLE	<input type="checkbox"/> FATALITY <input type="checkbox"/> BLEEDING OR DISTORTED WOUND <input type="checkbox"/> UNCONSCIOUSNESS <input type="checkbox"/> NO VISIBLE INJURY — COMPLAINED OF PAIN <input type="checkbox"/> OTHER _____	<input type="checkbox"/> PEDESTRIAN <input type="checkbox"/> IN YOUR VEHICLE <input type="checkbox"/> IN CLAIMANT VEHICLE

ADDITIONAL REMARKS

DESCRIBE ACCIDENT



WHAT STREET WERE YOU ON?
 WHAT DIRECTION WERE YOU TRAVELING?
 WEATHER CONDITIONS
 DRY WET ICY FOGGY SNOWY
 SPEED LIMIT



WHAT STREET WERE YOU ON?	CLAIMANT 1	CLAIMANT 2
WHAT DIRECTION WERE YOU TRAVELING?	CLAIMANT 1	CLAIMANT 2
WEATHER CONDITIONS <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY <input type="checkbox"/> FOGGY <input type="checkbox"/> SNOWY	TRAFFIC CONDITIONS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY	
SPEED LIMIT	WERE YOU FAMILIAR WITH AREA <input type="checkbox"/> YES <input type="checkbox"/> NO	TRAFFIC CONTROLS

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? YES NO

2. IN MY OPINION WE ARE AT FAULT FOR THIS ACCIDENT? YES NO

IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER? YES NO

IF REPORTED, NAME OF FIRM _____
 ADDRESS _____
 DATE ASSIGNED _____

DATE OF THIS REPORT	SIGNATURE AND TITLE
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