



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

GALLAGHER BASSETT SERVICES, INC. ACCIDENT REPORT, AUTO AND TRUCK

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

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

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 NUMBER

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 YES <input type="checkbox"/> NO <input type="checkbox"/>	ESTIMATED COST TO REPAIR \$

ACCIDENT					
DATE OF LOSS	TIME OF LOSS	LOCATION (STREET OR HIGHWAY)		CITY	STATE
WERE POLICE CALLED TO SCENE? YES <input type="checkbox"/> NO <input type="checkbox"/>	POLICE DEPT. CALLED	DRIVER	ARRESTED	TICKETED	VIOLATION
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 AGE	ADDRESS	CITY	STATE	ZIP	PHONE
DESCRIBE DAMAGED PROPERTY	LOCATION OF PROPERTY	CITY	STATE	ZIP	PHONE
WITNESS INFORMATION					
NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

PERSONS INJURED

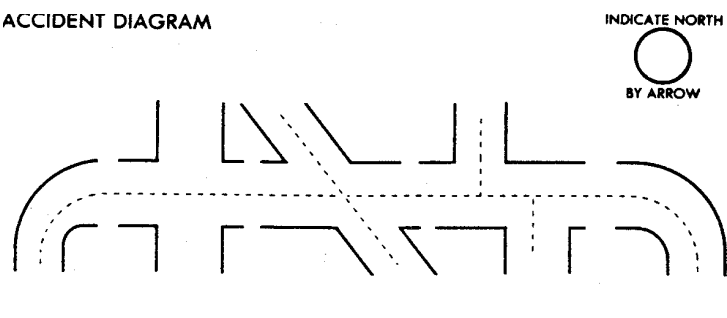
(USE ADDITIONAL SHEET IF NECESSARY)

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

ADDITIONAL REMARKS:



DESCRIBE ACCIDENT

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

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. IN MY OPINION WE ARE AT FAULT FOR THIS ACCIDENT?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IF REPORTED, NAME OF FIRM _____ ADDRESS _____ DATE ASSIGNED _____		
DATE OF THIS REPORT	SIGNATURE AND TITLE	