Passenger Vehicle Investigation Kit Checklist

_____ Employee Statement Form

_____ Other Driver Statement Form

_____ Vehicle Accident Form

_____ Vehicle Accident Guide

_____ Road Diagram

_____ Vehicle-Injured Party Form

_____ Witness Statement Form

_____ Passenger Auto Diagram

_____ Claim Activity Log

_____ Accident Photo Log

_____ Claim Handling Instructions

Employee Accident Statement

Employee Information

Employee Name: _____ Date of Accident: _____ Time: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

From and to Description: _____

Location of accident: _____

List injuries: _____

Description of Accident

Describe in detail the accident and how it occurred:

_____

USE THE BACK OF THIS FORM IF YOU NEED ADDITIONAL SPACE

I attest that I am over the age of 21, voluntarily gave this statement and it is true to the best of my ability and knowledge.

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Other Driver Statement Form

Date of accident: _____ Time: _____

Location of accident: _____

Injured Party(s)

Please list all injured party(s):

_____

USE THE BACK OF THIS FORM IF YOU NEED ADDITIONAL SPACE

I attest that I am over the age of 21, voluntarily gave this statement and it is true to the best of my ability and knowledge.

Signature:_____ Date:_____

Witnessed by:_____ Date:_____

Vehicle Accident Information Form

In the event of an accident, fill out the following information.

Date/Time of Accident _____

Accident Location _____

To & From Destination _____

Driver's Name _____

Passenger Name _____

Passenger Name _____

Other Vehicle Driver and contact information _____

Other Vehicle Passenger _____

Other Vehicle Passenger _____

Other Vehicle Owner and contact information _____

Other Vehicle Insurance Company and Policy Number _____

Investigating Officers' Name _____

Department and contact information _____

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In the event of an accident, fill out the following information.

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Accident Location _____

To & From Destination _____

Driver's Name _____

Passenger Name _____

Passenger Name _____

Other Vehicle Driver and contact information _____

Other Vehicle Passenger _____

Other Vehicle Passenger _____

Other Vehicle Owner and contact information _____

Other Vehicle Insurance Company and Policy Number _____

Investigating Officers' Name _____

Department and contact information _____

Vehicle Accident Guide

In case of an accident:

- STOP: Failure to stop is a serious violation. Do not move vehicle until police arrive, unless otherwise required by law.
- PROTECT THE SCENE: Turn on your flashers.
- NOTIFY POLICE: Request help for the injured parties. DO NOT move injured parties unless in immediate danger.
- REPORT the accident to your employer immediately.
- DO NOT make any statements about fault, DO NOT sign anything.
- DO NOT make any promises about payment for damages.
- Provide your name, address, license number and proof of insurance to involved parties and authorities.
- If there are any witnesses ask them to fill out a witness statement form.
- If the vehicle cannot be moved take steps to minimize the damage and prevent theft.
- Take pictures of the damages to vehicles with disposable camera (DO NOT photograph injured parties)
- Provide the completed information and forms to your employer or authorized representative only.

Unattended vehicle

- If you damage property or a vehicle and cannot locate the owner, leave your name, address and telephone number in a conspicuous place.

Medical Treatment

- If emergency care is needed use ambulance transport to the nearest hospital.
- If non-emergency treatment is needed our preferred provider is:

Place a label here _____

Vehicle Accident Guide

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- PROTECT THE SCENE: Turn on your flashers.
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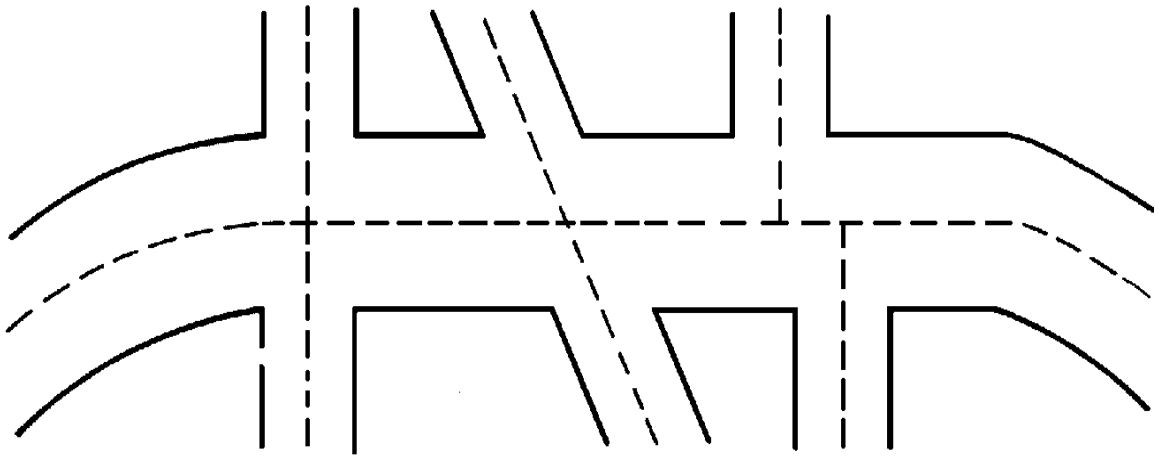
Road Condition and Accident Description Report



Vehicle/Injured Party Identification Form

Your Vehicle

Make	Model
Year	Plate #

Other Vehicles

#1

Make	Model
Year	Plate #
Driver's name and address	

#2

Make	Model
Year	Plate #
Driver's name and address	

#3

Make	Model
Year	Plate #
Driver's name and address	

Injured Parties

Name #1

Address

Phone #

Name #2

Address

Type of Injury

Phone #

Name #3

Address

Type of Injury

Phone #

Witness Accident Statement

Witness Information

Witness Name: _____ Is witness over 21? Yes: ☐ No: ☐

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

Home Phone: _____ Cell Phone: _____ E-mail: _____

Location & activity at time of accident: _____

Description of Accident

Describe in detail the accident and how it occurred:

_____

Vehicle Damage: Please describe damage to each vehicle:

_____

Injured Parties:

_____

USE THE BACK OF THIS FORM IF YOU NEED ADDITIONAL SPACE

I attest that I am over the age of 21, voluntarily gave this statement and it is true to the best of my ability and knowledge.

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

Passenger Vehicle Claim Activity Log

Claimant Name:		
Reference #:	**Date of Incident:**	**Claim #:**

Date	Time	Contact/Activity	Outcome of Contact/Activity

Vehicle Claim Handling Instructions

In the event someone is injured at your location report all claims by calling _____ on the date of the incident or at least within 24 hours.

Instructions: Initial and date each task as it is completed.

Initials	Date	
_____	_____	Review accident details with the driver.
_____	_____	Obtain photographs taken by the driver.
_____	_____	Get Case number on police accident report.
_____	_____	Obtain any statements taken at the scene i.e.: your driver other driver and any witnesses.
_____	_____	Complete the automobile worksheet.
_____	_____	Call in the claim.
_____	_____	Hold onto all documents until contacted by the handling adjuster.

Accident Photograph Sheet

Location #:	**Date of Incident:**
Incident Location:	**Injured Party:**
Reference #:	

Attach photo	**Photo Description:**

Attach photo	**Photo Description:**

AmTrust North America

An AmTrust Financial Company

Associated Industries Insurance Company
Rochdale Insurance Company
Technology Insurance Company
AmTrust Insurance Company of Kansas
Milwaukee Casualty Insurance Company
Security National Insurance Company
Trinity Lloyds Insurance Company
Wesco Insurance Company

Provide 24/7 Toll-Free Claim Reporting

For ALL States
Phone: (866) 272-9267
Fax: (775) 908-3724 or (877) 669-9140
Email: Amtrustclaims@qrm-inc.com

For Florida Workers Comp Only
Florida WC Only: (888) 225-2442
Fax: (561) 241-3257
Email: FLclaims@amtrustgroup.com

Information Required for All Claims reported.

1. Name of the insured and policy number
2. Date, Time & Place of Accident
3. Description of accident or incident
4. Name, phone and/or e-mail of person making the report

Additional Information Required for Specific Claim Types

A. For Workers' Compensation
   1. *MUST have the injured employee's social security number as it is required by law*
   2. Description of injury

B. For Property Claims
   1. Physical address of the loss
   2. If more than one building on property must have specific building(s) involved
   3. Type of loss, i.e., Fire, Theft, etc.
   4. Description of loss or damage

C. For Motor Vehicle (Auto) Claims
   1. Name, address and contact information of *ALL* parties involved.
   2. Make, model and VIN of the insured vehicle
   3. Make, model of all other vehicles involved
   4. Current location of all vehicles
   5. Name and contact information *for each driver and all passengers*
   6. Name and contact information any known witnesses

D. For General Liability Claims
   1. Physical address of where the loss occurred
   2. Name, address and contact information for all persons claiming injury or damage
   3. Name and contact information any known witnesses