



DEPARTMENT OF INSURANCE & RISK MANAGEMENT  
 COUNTY OF SUMMIT  
 175 S. MAIN STREET, ROOM #103  
 AKRON, OHIO 44308  
 330.643.2823 ♦ FAX: 330.643.7746

# AUTOMOBILE ACCIDENT REPORT

CLAIM NUMBER

**THIS IS A CONFIDENTIAL INTERNAL DOCUMENT**

CLAIMANT/EMPLOYEE LAST NAME			FIRST NAME		MIDDLE INITIAL		DATE OF BIRTH (YEAR/MONTH/DAY)		
HOME ADDRESS STREET				CITY/TOWN			STATE		ZIP CODE
HOME TELEPHONE NUMBER			INSURANCE COMPANY NAME/POLICY NUMBER						
INSURANCE COMPANY ADDRESS STREET				CITY/TOWN			STATE		ZIP CODE
INSURANCE COMPANY NUMBER									
MAKE OF VEHICLE		YEAR	MODEL	SERIAL NUMBER		LICENSE NUMBER/STATE			
DESCRIBE DAMAGE								ESTIMATE OF DAMAGE	
NAME OF DRIVER OF YOUR VEHICLE				AGE		DRIVER'S LICENSE NUMBER			
RESIDENCE ADDRESS STREET				CITY/TOWN			STATE		ZIP CODE
HOME TELEPHONE NUMBER									
DATE OF ACCIDENT (YEAR/MONTH/DAY)			TIME		WERE YOU WEARING A SEAT BELT?				
			<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.		<input type="checkbox"/> YES <input type="checkbox"/> NO				
LOCATION OF ACCIDENT									
PURPOSE VEHICLE USED FOR AT TIME OF ACCIDENT				WEATHER CONDITION			ROAD CONDITION		
YOUR SPEED		DIRECTION		OTHER'S SPEED		DIRECTION			
POLICE INVESTIGATION BY							CHARGES		
HAD YOU TAKEN ANY ALCOHOLIC BEVERAGES OR DRUGS PRIOR TO THE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
WHO WAS RESPONSIBLE FOR THE ACCIDENT? (REASON)									
OWNER OF OTHER VEHICLE				OWNER OF OTHER VEHICLE					
HOME TELEPHONE NUMBER				HOME TELEPHONE NUMBER					
HOME ADDRESS				HOME ADDRESS					
MAKE OF VEHICLE		YEAR		MAKE OF VEHICLE		YEAR			
MODEL		LICENSE NUMBER/STATE			MODEL		LICENSE NUMBER/STATE		
NAME OF INSURANCE COMPANY				NAME OF INSURANCE COMPANY					
DESCRIPTION OF DAMAGE				DESCRIPTION OF DAMAGE					
NAME OF DRIVER		HOME TELEPHONE NUMBER			NAME OF DRIVER		HOME TELEPHONE NUMBER		
HOME ADDRESS				HOME ADDRESS					

