

# **Instructions**

The Accident Report is for you to document what happened. Please include the name of GEICO insured, your claim number, and complete details related to the accident, then sign and date the form.

*(Form Below)*

# GOVERNMENT EMPLOYEES INSURANCE COMPANIES

GEICO INSURED

## REPORT OF ACCIDENT

GEICO CLAIM #

YOUR NAME		AGE	OCCUPATION	
ADDRESS (NUMBER) (STREET) (CITY) (STATE) (ZIP)			PHONE NO.	
			HOME	
NAME AND ADDRESS OF EMPLOYER			BUSINESS	
ARE YOU MARRIED? IF YES, GIVE FULL NAME OF SPOUSE: <input type="checkbox"/> YES <input type="checkbox"/> NO				
MAKE OF OUR INSURED'S AUTO	YEAR	MODEL	LIC NO	STATE
NAME AND ADDRESS OF OUR INSURED DRIVER			DRIVER'S LICENSE #	AGE
WHAT COMPANY(S) INSURES YOUR AUTOMOBILE	NAME OF COMPANY (S)		POLICY NO.	DOES THE POLICY CONTAIN MEDICAL COVERAGE FOR MEDICAL EXPENSES? <input type="checkbox"/> YES <input type="checkbox"/> NO
	PHONE #		CLAIM #	
DATE OF ACCIDENT	TIME M.	PLACE OF ACCIDENT		
MAKE OF YOUR AUTO	YEAR	MODEL	LIC. NO.	STATE
NAME AND ADDRESS OF REGISTERED OWNER				
NAME AND ADDRESS OF DRIVER			DRIVER'S LICENSE #	AGE
WAS DRIVER ON ERRAND FOR OWNER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FOR WHAT PURPOSE?				
NAME, ADDRESS, AND TELEPHONE NUMBER OF OCCUPANTS OF YOUR AUTOMOBILE:				
NAME		ADDRESS		TELEPHONE NO.
1				
2				
3				
4				
WERE YOU HURT? <input type="checkbox"/> YES <input type="checkbox"/> NO WAS ANYONE HURT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO, GIVE NAME, ADDRESS AND TEL. NO. OF OTHER PERSONS INJURED:				
NAME		ADDRESS		TEL. NO.
				SEAT BELTS IN USE? YES NO
1				<input type="checkbox"/> <input type="checkbox"/>
2				<input type="checkbox"/> <input type="checkbox"/>
3				<input type="checkbox"/> <input type="checkbox"/>
4.				<input type="checkbox"/> <input type="checkbox"/>
5				<input type="checkbox"/> <input type="checkbox"/>
NATURE OF YOUR INJURIES				
NAME AND ADDRESS OF DOCTOR				
NAMES AND ADDRESSES OF ALL WITNESSES (OTHER THAN OCCUPANTS OF YOUR CAR):				
NAME		ADDRESS		
IF AFTER DARK, WERE ALL VEHICLES LIGHTED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
CONDITION OF ROAD			WEATHER CONDITONS	

(PLEASE COMPLETE OTHER SIDE)

STATE FULL DETAILS OF HOW THE ACCIDENT HAPPENED:

WHERE CAN CAR BE SEEN DURING THE DAY?

LIST THE AREAS OF YOUR CAR WHICH WERE DAMAGED IN THE ACCIDENT:

DESCRIBE DAMAGED PROPERTY OTHER THAN YOUR AUTO

ARE YOU MAKING A CLAIM?

YES  NO

AGAINST WHOM?

FOR WHAT AMOUNT?

\$

DID YOU REPORT THE ACCIDENT TO POLICE?

YES  NO

WHERE? (DEPT. ADDRESS)

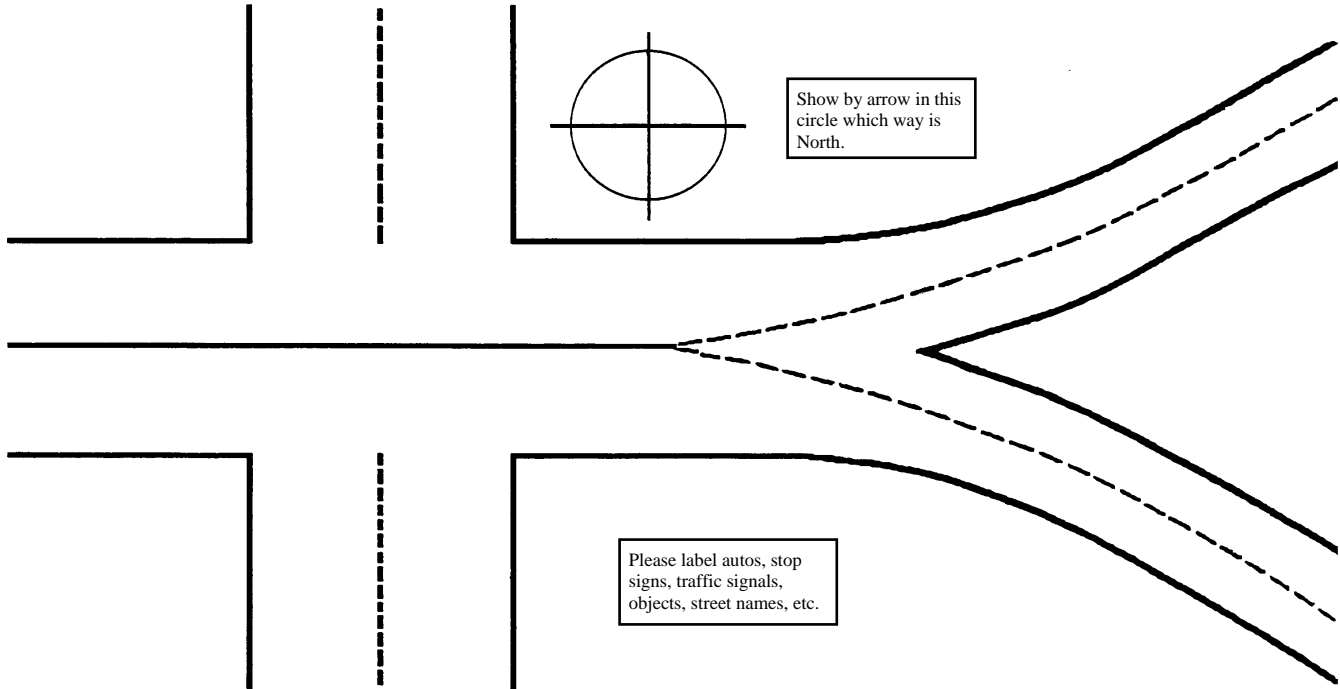
WAS ANYONE CHARGED?

YES  NO

WHO

CHARGES

DRAW A SKETCH OF THE ACCIDENT USING THIS DIAGRAM:



SIGNATURE

DATE

For your protection, California law requires the following to appear on this form:  
 Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.