

Instructions

The Accident Report is for you to document what happened. Please include your claim number, fill out Sections 1-9 and sign and date the form.

(Form Below)

GOVERNMENT EMPLOYEES INSURANCE COMPANIES
3535 WEST PIPKIN ROAD
LAKELAND, FL 33811

FOR REPORTING ACCIDENTS

Please complete this form as thoroughly as possible. All details of the accident are important to accurately process this claim.

CLAIM # _____

1. POLICYHOLDER AND DRIVER

Name of Policyholder _____	FULL FIRST	FULL MIDDLE	LAST
Policy Number _____	Occupation _____	Social Security No. _____	
Complete Home Address _____		Phone _____	
Business Address _____		Phone _____	
FULL FIRST	FULL MIDDLE	LAST	
Driver's Name _____	Address _____		Phone _____
Driver's License No. _____	State License Issued _____	Social Security No. _____	Driver's Age _____
Date of Birth _____	Years of driving experience _____	Relation to Policyholder _____	Who authorized him to drive? _____
Name Occupants of Policyholder's Car _____			

2. POLICYHOLDER'S AUTOMOBILE

Make _____	Year _____	Body Type _____	Model _____
License Plate No. and State _____		Identification # _____	
Name of Holder of Title, if not Policyholder _____			
Name of Owner if other than Policyholder _____		Address _____	
Car Permanently Garaged at _____			

3. DATE AND PLACE

Date of Accident _____ 20 _____	Time _____	A.M	P.M.	(Circle One)
Where did accident occur? _____		City _____ State _____		
Was car towed from scene of accident? _____		If so, by whom? _____		
Purpose for which car was being used: _____		Was driver on errand for owner? _____		
Current location of car: _____				
Has this claim been previously reported? _____				

4. THE ACCIDENT (GIVE COMPLETE DETAILS)

Direction my automobile was going _____

What side of street? _____ How fast? _____ Speed Limit? _____ Were your headlights on? _____ Signals? _____

Condition of street? _____ If object collided with was moving, in what direction was it going? _____

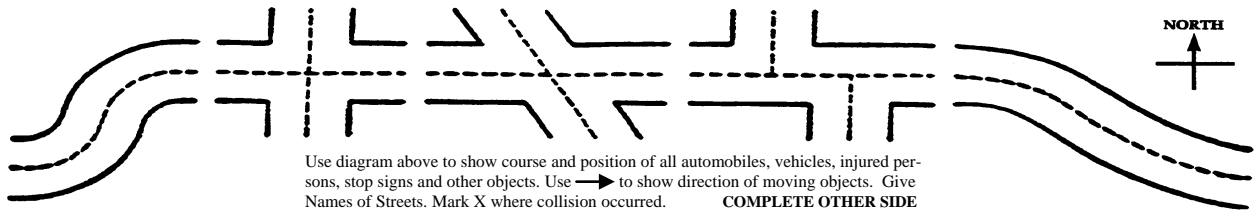
How fast? _____ What side of Street? _____ Any signals given? _____ If an automobile, were lights on? _____

Was either driver violating traffic regulation? _____ Were traffic controls present? _____ If so, indicate where and type on diagram below.

Was accident investigated by police? _____ What Department and Precinct? _____

Was anyone charged? _____ Who? _____ What was the charge? _____

State Full Details Of How Accident Happened:



Use diagram above to show course and position of all automobiles, vehicles, injured persons, stop signs and other objects. Use → to show direction of moving objects. Give Names of Streets. Mark X where collision occurred. **COMPLETE OTHER SIDE**

5. PERSONAL INJURIES

Name of injured person _____

Address _____

Age _____ Occupation _____ Social Security No. _____

Injuries _____

Name and address of treating Doctor _____

Where was injured person taken? _____

Where was injured person at time of accident? _____ Seat Belts In Use? Yes No

What statement was made by injured person? _____

Do you anticipate claim being made against you? _____

6. OTHER CAR OR PROPERTY INVOLVED (NOT YOUR CAR)

Name and address of owner of damaged auto or other property damaged. _____

Home Phone _____ Business Phone _____ Social Security No. _____

Name of other party's insurance carrier _____ Policy No. _____

Make of automobile _____ Year _____ Body Type _____ Model _____

Describe damage to auto or other property _____

License Plate No. and State _____ Estimated Repair Cost \$ _____

Name of Driver of other car _____ Address _____

Drivers License No. _____ Social Security No. _____ Age of Driver _____

Occupants of other car _____ Address _____

_____ Address _____

Where can investigator see other car? _____

What was said between you and other driver _____

IMPORTANT: Is claim being made against you? _____ Are you making claim against the other party? _____

7. DAMAGE TO POLICYHOLDER'S AUTOMOBILE:

State cause of damage or loss if other than accident _____

Date of loss _____

Describe parts, nature and extent of loss _____

Estimated cost of repairs \$ _____

If theft, were police notified? _____ When _____ Officer's name and number _____

Give make, size and mileage of tires stolen or damaged _____

Age of convertible top _____ Purchase date and warranty of battery _____

8. WITNESSES / THIS IS IMPORTANT

The names and addresses of all witnesses, bystanders or people in the immediate vicinity who may have seen the accident or heard any statement made, should be listed.

Name _____ Telephone No. _____ Social Security No. _____

Address _____ City _____ State _____

Name _____ Telephone No. _____ Social Security No. _____

Address _____ City _____ State _____

For your protection, Florida law requires the following to appear on this form:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

9. CERTIFICATE

I certify that the foregoing is correct to the best of my knowledge and belief.

Policyholder's Signature _____

Date of this report _____

Driver's Signature
(If other than Policyholder) _____