# GOVERNMENT EMPLOYEES INSURANCE COMPANIES
**Buffalo/New Jersey Claims, PO BOX 9515**
**Fredericksburg, VA 22403-9515**

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

CLAIM #

FULL FIRST FULL MIDDLE LAST

**1. POLICYHOLDER AND DRIVER** Name of Policyholder _____

Policy Number _____ Occupation _____ Social Security No. _____

Complete Home Address _____ E-Mail _____ 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? _____

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

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

**State Full Details Of How Accident Happened:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**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_____

**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) _____