

Immediately after an accident fill out this form and send to:
 Nancy Davis - ACC Insurance Dept.
 3424 Wilshire Blvd-LA, CA 90010
 Fax: 213-637-6168 / email: ndavis@la-archdiocese.org



GALLAGHER BASSETT SERVICES, INC.

ACCIDENT REPORT, AUTO AND TRUCK

(FOR BODILY INJURY OR DAMAGE TO ANOTHER'S PROPERTY OR FOR DAMAGE TO YOUR VEHICLE)

LOCATION CODE:

THIS ACCIDENT RESULTED IN:
 BODILY INJURY
 PROPERTY DAMAGE ONLY

CLIENT												
NAME			PHONE		DRIVER NAME			PHONE		DATE OF BIRTH		
ADDRESS					ADDRESS					NUMBER OF YEARS WITH COMPANY		
CITY		STATE		ZIP		CITY		STATE		ZIP		
DRIVER-S LICENSE NUMBER												
VEHICLE												
MAKE OF YOUR VEHICLE			YEAR	MODEL		SERIAL NUMBER		LICENSE NUMBER		WHERE VEHICLE CAN BE SEEN		
TRAILER (IF APPLICABLE)		YEAR	MODEL		AREA OF DAMAGE			USED FOR BUSINESS YES <input type="checkbox"/> NO <input type="checkbox"/>		ESTIMATED COST TO REPAIR \$		
ACCIDENT												
DATE OF LOSS			TIME OF LOSS			LOCATION (STREET OR HIGHWAY)			CITY		STATE	
WERE POLICE CALLED TO SCENE? YES <input type="checkbox"/> NO <input type="checkbox"/>			POLICE DEPT. CALLED			DRIVER		ARRESTED	TICKETED	VIOLATION		
NAME OF OFFICER			BADGE NUMBER									
STATION ADDRESS												
CLAIMANT 1												
OWNER OF OTHER VEHICLE			AGE	ADDRESS			CITY		STATE	ZIP	PHONE	
DRIVER, IF OTHER THAN ABOVE			AGE	ADDRESS			CITY		STATE	ZIP	PHONE	
MAKE OF VEHICLE	YEAR	MODEL		LICENSE NO.		AREA OF DAMAGE		ESTIMATE OF DAMAGE \$		WHERE CAN VEHICLE BE SEEN		
CLAIMANT 2												
OWNER OF OTHER VEHICLE			AGE	ADDRESS			CITY		STATE	ZIP	PHONE	
DRIVER, IF OTHER THAN ABOVE			AGE	ADDRESS			CITY		STATE	ZIP	PHONE	
MAKE OF VEHICLE	YEAR	MODEL		LICENSE NO.		AREA OF DAMAGE		ESTIMATE OF DAMAGE \$		WHERE CAN VEHICLE BE SEEN		
PROPERTY DAMAGE--OTHER THAN AUTO (ie. FENCE, CANOPY)												
OWNER OF PROPERTY				ADDRESS			CITY		STATE	ZIP	PHONE	
DESCRIBE DAMAGED PROPERTY				LOCATION OF PROPERTY			CITY		STATE	EXTENT OF DAMAGE		
WITNESS INFORMATION												
NAME			ADDRESS			CITY		STATE	ZIP	PHONE		
NAME			ADDRESS			CITY		STATE	ZIP	PHONE		

NOTE: PLEASE COMPLETE REVERSE SIDE

PERSONS INJURED

(USE ADDITIONAL SHEET IF NECESSARY)

NAME	AGE	NAME	AGE
ADDRESS	PHONE	ADDRESS	PHONE
CITY	STATE	ZIP	CITY
CITY	STATE	ZIP	CITY
OCCUPATION	WHERE TAKEN	OCCUPATION	WHERE TAKEN
<input type="checkbox"/> FATALITY	<input type="checkbox"/> PEDESTRIAN	<input type="checkbox"/> FATALITY	<input type="checkbox"/> PEDESTRIAN
<input type="checkbox"/> BLEEDING OR DISTORTED WOUND	<input type="checkbox"/> IN YOUR VEHICLE	<input type="checkbox"/> BLEEDING OR DISTORTED WOUND	<input type="checkbox"/> IN YOUR VEHICLE
<input type="checkbox"/> UNCONSCIOUSNESS	<input type="checkbox"/> IN CLAIMANT VEHICLE	<input type="checkbox"/> UNCONSCIOUSNESS	<input type="checkbox"/> IN CLAIMANT VEHICLE
<input type="checkbox"/> NO VISIBLE INJURY-- COMPLAINED OF PAIN		<input type="checkbox"/> NO VISIBLE INJURY-- COMPLAINED OF PAIN	
<input type="checkbox"/> OTHER _____		<input type="checkbox"/> OTHER _____	

ADDITIONAL REMARKS:

DESCRIBE ACCIDENT

<p>WHAT STREET WERE YOU ON?</p> <p>WHAT DIRECTION WERE YOU TRAVELING?</p> <p>WEATHER CONDITIONS <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY <input type="checkbox"/> FOGGY <input type="checkbox"/> SNOWY</p> <p>SPEED LIMIT</p>	<p style="text-align: center;">VEHICLES → <input type="checkbox"/> 1 <input type="checkbox"/> 2 ← PEDESTRIAN ○</p> <p style="text-align: center;">ACCIDENT DIAGRAM</p> <p style="text-align: right;">INDICATE NORTH BY ARROW</p>
CLAIMANT 1	CLAIMANT 2
CLAIMANT 1	CLAIMANT 2
TRAFFIC CONDITIONS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODERATE <input type="checkbox"/> HEAVY	
WERE YOU FAMILIAR WITH AREA <input type="checkbox"/> YES <input type="checkbox"/> NO	TRAFFIC CONTROLS

THIS SECTION MUST BE COMPLETED BY SUPERVISOR

1. DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU?	<input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. IN MY OPINION WE ARE AT FAULT FOR THIS ACCIDENT?	<input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER?	<input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
IF REPORTED, NAME OF FIRM	_____		
ADDRESS	_____		
DATE ASSIGNED	_____		
DATE OF THIS REPORT	SIGNATURE AND TITLE		