



ZURICH^{MC}

Claims Reporting Form - Automobile

Fax to: 1-877-977-8077 or Email to: claims@zurich.com

General Information		
Name of person reporting	Telephone number	For reporting only <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Broker	Broker telephone number	Broker fax number

Insured's Information		
Name and address of the Insured (including postal code)		Business telephone (incl.ext.) Ext. Cellular number
Contact name	Contact e-mail address	Contact language spoken

Policy Information		
Policy number	Policy period (dd/mm/yyyy) From To	Certificate number (if applicable)
Lienholder/Other Insurance		
Coverage (Type of policy form, limits, deductible)		

Accident Information		
Address where loss occurred	Date of loss (dd/mm/yyyy)	Time of loss
	Province or State/Country	
Please give description of loss		
No. of occupants in each vehicle including driver Insured's Third party's	Were seatbelts in use at time of loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were citations/charges issued? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom?	For what violation?
Were the authorities contacted (police, fire, ambulance)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was a report number given? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list number
If Police/Fire Department contacted, name of officer	Division	Badge number

Insured's Vehicle Information			
Driver's name and address (including postal code)	Home telephone	Work telephone	Date of birth (dd/mm/yyyy)
	Social Insurance No.	Driver's license no.	Class
Owner's name and address		Home telephone	Work telephone
Lessor's name and address (if not owned)		Home telephone	Work telephone
Vehicle year	Make	Model	VIN number
License plate number		Province of issue	
Vehicle's current location		Area of damage	Estimate (\$)
		Telephone number	

Description of damage/include cargo if applicable	
Current status of vehicle <input type="checkbox"/> Drivable <input type="checkbox"/> Towed from accident scene	Were there injuries in this vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name and address of injured party	Telephone number
Name and address of medical provider	
Doctor's name	Telephone number Medical attention given

Claimant Information – Other Vehicle			
Driver's name and address (including postal code)	Home telephone	Work telephone	Date of birth (dd/mm/yyyy)
	Social Insurance No.	Driver's license no.	Class
Covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Company name			
Contact name		Telephone number	
Owner's name and address		Home telephone	Work telephone
Lessor's name and address (if not owned)		Home telephone	Work telephone
Vehicle year	Make	Model	VIN number
		License plate number	Province of issue
Vehicle's current location		Area of damage	Estimate (\$)
		Telephone number	
Description of damage/include cargo if applicable			
Current status of vehicle <input type="checkbox"/> Drivable <input type="checkbox"/> Towed from accident scene		Were there injuries in this vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of injured party		Telephone number	
Name and address of medical provider			
Doctor's name		Telephone number Medical attention given	

Additional vehicles and claimants should be listed on an additional reporting form. Please attach.

Witness Information
Name and address of a witness to the incident
Telephone number where witness can be reached

Additional Injury Information			
Name and address of additional injured party			
Nature of injury	Body part	Party's telephone	Location <input type="checkbox"/> Insured's vehicle <input type="checkbox"/> Other vehicle <input type="checkbox"/> Pedestrian
Name and address of medical provider			
Doctor's name		Telephone number	

Anything related to the incident you would like to add
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