

AUTO ACCIDENT REPORT

Insured: _____ Address: _____

Name of person completing form: _____ Phone: _____
(Area code + number)

Date of Accident: _____ Location: _____
(Street or Hwy) (City and State)

Description (how did the accident happen?): _____

Police Report? Yes No Police Dept. _____
(Name of City Police or State Hwy. Patrol)

Report/Incident Number: _____

Insured vehicle:

Year _____ Make/Model _____ VIN: _____

Insured Driver: _____

Is IV damaged? Yes No Where? _____
(i.e. left front; right rear; front end; rear, etc.)

Claimant vehicle:

Year _____ Make/Model _____ License plate: _____

Is Vehicle Damaged? Yes No Where? _____
(i.e. left front; right rear; front end; rear, etc.)

Owner's Name: _____ Phone: _____
(Area code + number)

Owner's Work or Cell Phone: _____
(Area code + number)

Mailing Address: _____
(P.O. Box or Street address, City, State and Zip Code)

Driver's name & phone if different: _____

Was anyone injured? Yes No Name(s): _____

Extent of injury: _____ Transported to hospital? Yes No

Witnesses:

Name: _____ Phone: _____
(Area code + number)

Work or Cell Phone: _____
(Area code + number)

**FAX COMPLETED FORM TO: Helen Watson @ MHBT – 972-376-8101 or Phone: 972-770-1653
or E-mail to helen_watson@mhbt.com**