



POLICYHOLDER INFORMATION

Name of Driver

Driver License #

Company Name

Company's Commercial Auto Insurance Policy #

ACCIDENT / LOSS

Date of Accident Time of Accident

Location of Accident—Street

City State

Accident Description

AUTHORITY CONTACTED

Name of Officer Badge #

Name of Person to Whom Citation Was Issued (if any)

INSURED VEHICLE

VIN/Year/Make/Model

Plate # State

Damage

Injuries to Driver

OTHER VEHICLE

VIN/Year/Make/Model

Driver Ins Company Policy #

Name of Driver License #

Address of Driver

City State Zip

Phone

Name of Owner (if different from driver)

Address of Owner

City State Zip

Describe Damage

Describe Injuries to Driver

OTHER PERSONS INJURED

Name

Other Passenger in Insured Vehicle Passenger in Other Vehicle

Address Phone

City State Zip

OTHER PERSON'S INJURED, CONTINUED

Extent of Injury

Name

Address Phone

City State Zip

Extent of Injury

WITNESSES

Name

Other Passenger in Insured Passenger in Other

Address Phone

NOTE: If you need more room, please use the space provided on the back of this form. Be sure to fax that side as well.

FAX THIS ACCIDENT REPORT TO:
YORK Call Center
Fax (800) 919-8984
York Claims Service, Inc.
3 AAA Drive, Suite 201
Robbinsville, NJ 08691
Toll Free Tel (866) 391-YORK
ATPA@york-claims.com
Client Code 2438

Keep this form in your vehicle at all times. Additional Accident Report Forms may be obtained from your fleet supervisor.