

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		
<input type="checkbox"/> Other	<input type="checkbox"/> Passenger in Insured Vehicle	<input type="checkbox"/> 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		
<input type="checkbox"/> Other	<input type="checkbox"/> Passenger in Insured	<input type="checkbox"/> Passenger in Other
Address		Phone
<p>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.</p> <p style="text-align: center;">FAX THIS ACCIDENT REPORT TO: YORK Call Center-Client Code #1967 Fax (800) 393-8104 York Claims Service, Inc. 99 Cherry Hill Road Parsippany, NJ 07054 Toll Free Tel (866) 391-YORK yorkclaimsintake@york-claims.com</p>		
<p>Keep this form in your vehicle at all times. Additional Accident Report Forms may be obtained from your fleet supervisor.</p>		
		