SUTTER INSURANCE
AUTOMOBILE CLAIM REPORT

Today's Date: ____________________ Canceled Date: ____________________

Reported By: ____________________ Phone: ____________________

Policy Number: ____________________ Effective From: ____________________ To: ____________________

*Coverage Information:

Bodily Injury Property Damage Medical Payments Comp/Coll. Ded. UIM

* Loss Payee: ____________________

* Producer Name: ____________________ Code: ____________________

LOSS INFORMATION

Date of Loss: ____________________ Time: ____________ ☐ AM ☐ PM

Location of Accident: ____________________
(Including City and State)

Description of Accident:

Police Department & Report No.: ____________________ Code: ____________________

INSURED'S INFORMATION

Name: ____________________

Address: ____________________

Contact No. (H): ____________________ (W) ____________________ Email: ____________________

Insured Vehicle No.: _____ Year: _______ Make: ____________ Plate: __________ VIN: __________

What part of vehicle was damaged? ____________________

Towed? ☐ Estimate $ ____________________

Where can vehicle be seen? (eg. residence, tow yard?) ____________________

Registered Owner of Above Vehicle:
Name: ____________________
Address: ____________________
Contact No.: (H) ____________________ (W) ____________________

Driver of Above Vehicle:
Name: ____________________
Address: ____________________
Contact No.: (H) ____________________ (W) ____________________
DOB: ____________________ CDL: ? ____________________

Add'l Vehicle (i.e. trlr): Year: __________ Make: ____________ Plate: __________ VIN: __________

Cargo ☐ Yes ☐ No Type of Cargo ____________________

Damaged ☐ Yes ☐ No Extent of Damage ____________________

OTHER PARTY/CLAIMANT INFORMATION:

Vehicle Description:: Year: ______ Make: ______ Plate: ______ VIN: ______

What part of vehicle was damaged? ______

Towed? ☐ Estimate $ ______

Where can vehicle be seen? (eg. residence, tow yard?) ______

Insurance Company: ______ Policy No.: ______

Registered Owner of Above Vehicle: Name: ______
Address: ______
Contact No.: (H) ______ (W) ______

Driver: Name: ______
Address: ______
Contact No.: (H) ______ (W) ______
DOB: ______ CDL: ______

Add'l Vehicle (i.e. trlr): Year: ______ Make: ______ Plate: ______ VIN: ______

INJURY INFORMATION ☐ O/I ☐ O/P

Name: ______
Address: ______
Phone: ______ Date of Birth: ______
Extent of Injuries: ______

INJURY INFORMATION ☐ O/I ☐ O/P

Name: ______
Address: ______
Phone: ______ Date of Birth: ______
Extent of Injuries: ______

WITNESS OR PASSENGER INFORMATION

☐ Witness: Name: ______ Phone: ______

☐ Passenger ☐ O/I Vehicle: Name: ______ If Child-age ______
Name: ______ Child Car Seat in Use? ☐ Yes ☐ No
☐ O/P Vehicle: Name: ______ If Child-age
Name: ______ Child Car Seat in Use? ☐ Yes ☐ No

For your protection, State Law requires the following to appear on this form: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON".

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

By submitting this form I declare this information to be true and correct.

Email to claimsemail@sutterinsurance.com
Fax to 707-793-0909

Taken By: ______