INSURANCE
AGENCY

Auto Claim Form

Date of Accident: ________________ **Name of Insured:** ______________________________________

Insured Vehicle: Year/Make/Model: _____________________________ **Last 6 of VIN#:** _____________

Insured Driver Name and Phone Number: ____

Damage to Vehicle: ____

Location of Accident: ____

Your Contact's Name & Number to speak to Adjuster: ____

Description of Accident: ____

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Other Property or Other Vehicle Owner's Name & Number: ___________________________________

Driver's Name/Number: ____

Vehicle's Year/Make/Model: ____

Damage to Vehicle: ____

Insurance Company's Name/Number: ____

Insurance Policy Number: ____

Police Department and Case Number: ____

Injury: ___________ **Insured or Other Vehicle Name/Number:** _______________________________

Description of Injury: ____

Injury: ___________ **Insured or Other Vehicle Name/Number:** _______________________________

Description of Injury: ____

Additional Information: ____

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Completed By: ____ **Date:** _________________

Return to: Cherry Guidry at cguidry@vfistx.com or Phone: 512-628-5184 Fax: 512-448-9929

Marena Williams at mwilliams@vfistx.com Phone: 512-628-5055 Fax: 512-448-9929