



Client Name:		Contract Number:	
Reporter Information			
First Name:		Last Name:	
Title:	Phone:	Ext:	
Client Location Information			
Location Number:		Location Name:	
Street Address:			
City:	State:	Zip Code:	
Phone:		Ext:	
Is this the loss location? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Incident Information			
Date of Incident:	Time of Incident:	AM <input type="checkbox"/>	PM <input type="checkbox"/>
Date Employer Notified:			
Incident Description:			
Road Conditions: Select One	Weather Conditions: Select One	Speed Limit?	
Was the Driver Wearing a Seatbelt? Select One	Was the Driver using a Cell Phone? Select One		
Incident Location Information (If different from above)			
Incident Location Name:			
Street Address:			
City:	State:	Zip Code:	
Authority Information			
Authority Name:		Phone:	Ext:
Authority Report Number:		Officer Name:	
Insured Driver Information			
Employee ID:		SSN:	
First Name:	MI:	Last Name:	
Home Phone:	Work Phone:	Ext:	
Home Address:			
City:	State:	Zip Code:	
Date of Birth:			
Marital Status: Select One		Gender: Select One	
Drivers License #:		State:	
Citation Issued?: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Injury Information			
Description of Injury			
Cause:		Body Part	
Nature:			
Medical Treatment Information			
Admitted to Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Facility Name:			
Street Address:			
City:	State:	Zip Code:	
Phone:		Ext:	
Transportation Type: Select One			
Insured Vehicle Information			
Vehicle Fleet Number:			
VIN:			

Sedgwick Auto Liability Intake Form
 Email: SCMSNIC@Sedgwickcms.com Fax: 1-866-261-5795



Body Type:		Year:		Make:	
Model:			Color:		
License Plate Number:			State:		
Damage Description:					
Estimated Damage:		Towed: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Part:			Cause:		
When/Where Can Property Be Seen (If not drivable)					
Name:					
Street Address:					
City:		State:		Zip Code:	
Phone :					
Other Driver Information					
Employee ID:					
First Name:		MI:		Last Name:	
Home Phone:		Work Phone:		Ext:	
Home Address:					
City:		State:		Zip Code:	
Date of Birth:		Marital Status: Select One		Gender: Select One	
Drivers License #:			State:		
Citation Issued?: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Injury Information					
Description of Injury					
Cause:			Body Part		
Nature:					
Medical Treatment Information					
Admitted to Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Facility Name:					
Street Address:					
City:		State:		Zip Code:	
Phone:			Ext:		
Transportation Type: Select One					
Other Vehicle Information					
Vehicle Fleet Number:					
VIN:					
Body Type:		Year:		Make:	
Model:			Color:		
License Plate Number:			State:		
Damage Description:					
Estimated Damage:		Towed: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Part:			Cause:		
When/Where Can Property Be Seen (If not drivable)					
Name:					
Street Address:					
City:		State:		Zip Code:	
Damaged Property Information					
Describe Property:					
Damage Description:					
Estimated Damage:					
Other Insurance Information					
Carrier Name:			Phone Number:		

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<i>Injured Party Information</i>		
First Name:	MI:	Last Name:
Home Phone:	Work Phone:	Ext:
Home Address:		
City:	State:	Zip Code:
Date of Birth:	Marital Status: Select One	Gender: Select One
Drivers License #:	State:	
<i>Injury Information</i>		
Injury Description:		
Cause:	Body Part:	
Nature:		
<i>Medical Treatment Information</i>		
Admitted to Hospital? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Transportation Type: Select One		
<i>Witness Information</i>		
Name:		
Address:		
City:	State:	Zip Code:
Phone Number:		
<i>Contact Information</i>		
First Name:	MI:	Last Name:
Phone:	Ext:	Email Address:
<i>Comments/Remarks:</i>		