Auto Claim

Begin Your Claim

Asterisk (*) indicates required field

Name of Person Reporting Claim:

* First Name * Last Name

* Address

* City * State * Zip Code

Home Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000

Cell Phone 000 - 000 - 0000 *At least one phone number required.

E-mail

A copy of this Web Reported Claim will be sent to the above e-mail address.

* Date of Loss 00 / 00 / 0000

Approximate Time of Loss 00 : 00 AM

Are you a party to the claim? Yes No

What is your relationship to the claim?

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.

Auto Claim

Policyholder Information

Asterisk (*) indicates required field

* Company Name

* First Name * Last Name

Address

City State Zip Code

Home Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000

Cell Phone 000 - 000 - 0000 *At least one phone number required.

E-mail

Preferred Contact Other

Policy #

Was the Policyholder involved in the accident? Yes No

Was anyone injured? Yes No

Was there damage to property other than the Policyholder's? Yes No

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.

Auto Claim

Claim Details

Asterisk (*) indicates required field

* Address or Intersection of Accident

* City

* State

Zip Code

Briefly describe what happened in the incident

Were local authorities notified or on the scene? ◯ Yes ◯ No

Agency Name/Precinct

Report Number

Officer/Authority Name

Badge Number

Was anyone cited for the accident? ◯ Yes ◯ No

Who was cited?

What was the citation for?

How many vehicles were involved in this loss?

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Auto Claim

Vehicle Information (1 of 2 pages)

Asterisk (*) indicates required field

Our Policyholder's Vehicle:

Vehicle Type: * VIN #

Vehicle Year Make Model Color

License Plate: State / # Is the vehicle drivable? Yes No

Describe damage to vehicle

Where is the vehicle now?

Owner of Vehicle: Click here if Policyholder

* First Name * Last Name

* Address

* City * State * Zip Code

Home Phone 000 - 000 - 0000 Cell Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000 *At least one phone number required.

E-mail

Was owner in the vehicle at time of accident? Yes No

Driver of Vehicle: Click here if Policyholder

* First Name * Last Name

* Address

* City * State * Zip Code

Home Phone 000 - 000 - 0000 Cell Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000 *At least one phone number required.

E-mail

Was the driver injured in the accident? Yes No

Describe the driver's injury

Where is the vehicle now?

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Auto Claim

Vehicle Information (2 of 2 pages)

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Other Vehicle Information *(if applicable)*:

Vehicle Type: * VIN #

Vehicle Year Make Model Color

License Plate: State / # Is the vehicle drivable? Yes No

Describe damage to vehicle

Where is the vehicle now?

Owner of Other Vehicle:

* First Name * Last Name

* Address

* City * State * Zip Code

Home Phone 000 - 000 - 0000 Cell Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000 *At least one phone number required.

E-mail

Was owner in the vehicle at time of accident? Yes No

Driver of Other Vehicle:

* First Name * Last Name

* Address

* City * State * Zip Code

Home Phone 000 - 000 - 0000 Cell Phone 000 - 000 - 0000

Work Phone 000 - 000 - 0000 ext 00000 *At least one phone number required.

E-mail

Was the driver injured in the accident? Yes No

Describe the driver's injury

Where is the vehicle now?

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Auto Claim

Other Parties Involved (1of 2 pages)

Asterisk (*) indicates required field

* First Name		* Last Name		
* Address				
* City		* State		* Zip Code
* Home Phone	000 - 000 - 0000	Cell Phone	000 - 000 - 0000	
Work Phone	000 - 000 - 0000	ext	00000	*At least one phone number required.
E-mail				
How were they involved?				
In relation to what Vehicle?				
Was this person injured?	◯ Yes	◯ No		
If yes, please describe the injuries?				

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Auto Claim

Other Parties Involved (2 of 2 pages)

Asterisk (*) indicates required field

* First Name		* Last Name		
* Address				
* City		* State		* Zip Code
* Home Phone	000 - 000 - 0000	Cell Phone	000 - 000 - 0000	
Work Phone	000 - 000 - 0000	ext	00000	*At least one phone number required.
E-mail				
How were they involved?				
In relation to what Vehicle?				
Was this person injured?	◯ Yes	◯ No		
If yes, please describe the injuries?				

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Auto Claim

Summary

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Your claim is now ready for submission.
Please review all claim information and make any changes needed before submitting.

Is there anything else that you would like to note?

When you have completed this form, please save a copy for yourself and email the form and any attachments to reportaclaim@narisk.com. We will send you an acknowledgment electronically that we have received it.

We appreciate the time you are taking to complete this claim. Entering as much information as you can provide will expedite handling. For questions or problems, please contact us.