

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

Work Phone ext

Cell Phone *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

Approximate Time of Loss

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 | <input type="text"/> | | |
| * First Name | <input type="text"/> | * Last Name | <input type="text"/> |
| Address | <input type="text"/> | | |
| City | <input type="text"/> | State | Zip Code <input type="text"/> |
| Home Phone | <input type="text" value="- -"/> | | |
| Work Phone | <input type="text" value="- -"/> | ext | <input type="text"/> |
| Cell Phone | <input type="text" value="- -"/> | <i>*At least one phone number required.</i> | |
| E-mail | <input type="text"/> | | |
| Preferred Contact | <input type="radio"/> | Other | <input type="text"/> |
| Policy # | <input type="text"/> | | |
| Was the Policyholder involved in the accident? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Was anyone injured? | <input type="radio"/> Yes | <input type="radio"/> No | |
| Was there damage to property other than the Policyholder's? | <input type="radio"/> Yes | <input type="radio"/> 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?

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

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 - - Cell Phone - -

Work Phone - - ext *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 - - Cell Phone - -

Work Phone - - ext *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?

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

Vehicle Information (2 of 2 pages)

Asterisk (*) indicates required field

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 - - Cell Phone - -

Work Phone - - ext *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 - - Cell Phone - -

Work Phone - - ext *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?

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

Other Parties Involved (1 of 2 pages)

Asterisk (*) indicates required field

| | | | |
|--------------|----------------------------------|-------------|----------------------------------|
| * First Name | <input type="text"/> | * Last Name | <input type="text"/> |
| * Address | <input type="text"/> | | |
| * City | <input type="text"/> | * State | * Zip Code <input type="text"/> |
| * Home Phone | <input type="text" value="- -"/> | Cell Phone | <input type="text" value="- -"/> |
| Work Phone | <input type="text" value="- -"/> | ext | <input type="text"/> |
| E-mail | <input type="text"/> | | |

How were they involved?

In relation to what Vehicle?

Was this person injured? Yes No

If yes, please describe the injuries?

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

Other Parties Involved (2 of 2 pages)

Asterisk (*) indicates required field

| | | | |
|--------------|----------------------------------|-------------|----------------------------------|
| * First Name | <input type="text"/> | * Last Name | <input type="text"/> |
| * Address | <input type="text"/> | | |
| * City | <input type="text"/> | * State | * Zip Code <input type="text"/> |
| * Home Phone | <input type="text" value="- -"/> | Cell Phone | <input type="text" value="- -"/> |
| Work Phone | <input type="text" value="- -"/> | ext | <input type="text"/> |
| E-mail | <input type="text"/> | | |

How were they involved?

In relation to what Vehicle?

Was this person injured? Yes No

If yes, please describe the injuries?

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 Summary

Asterisk (*) indicates required field

**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 reportclaim@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.