



ZURICH®

Claims Reporting Form - Automobile

Fax to: 1-877-977-8077 or Email to: claims@zurich.com

General Information		
Name of person reporting	Telephone number	For reporting only <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Broker	Broker telephone number	Broker fax number

Insured's Information		
Name and address of the Insured (including postal code)		Business telephone (incl.ext.) Ext.
		Cellular number
Contact name	Contact e-mail address	Contact language spoken

Policy Information		
Policy number	Policy period (dd/mm/yyyy) From To	Certificate number (if applicable)
Lienholder/Other Insurance		
Coverage (Type of policy form, limits, deductible)		

Accident Information		
Address where loss occurred	Date of loss (dd/mm/yyyy)	Time of loss
	Province or State/Country	
Please give description of loss		
No. of occupants in each vehicle including driver Insured's Third party's	Were seatbelts in use at time of loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were citations/charges issued? <input type="checkbox"/> Yes <input type="checkbox"/> No	To whom?	For what violation?
Were the authorities contacted (police, fire, ambulance)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was a report number given? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list number
If Police/Fire Department contacted, name of officer	Division	Badge number

Insured's Vehicle Information			
Driver's name and address (including postal code)		Home telephone	Work telephone
		Date of birth (dd/mm/yyyy)	
		Social Insurance No.	Driver's license no.
		Class	
Owner's name and address		Home telephone	Work telephone
Lessor's name and address (if not owned)		Home telephone	Work telephone
Vehicle year	Make	Model	VIN number
		License plate number	Province of issue
Vehicle's current location		Area of damage	Estimate (\$)
		Telephone number	

Description of damage/include cargo if applicable		
Current status of vehicle <input type="checkbox"/> Drivable <input type="checkbox"/> Towed from accident scene	Were there injuries in this vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of injured party		Telephone number
Name and address of medical provider		
Doctor's name	Telephone number	Medical attention given

Claimant Information – Other Vehicle

Driver's name and address (including postal code)	Home telephone	Work telephone	Date of birth (dd/mm/yyyy)
	Social Insurance No.	Driver's license no.	Class
Covered by other insurance? If Yes, Company name <input type="checkbox"/> Yes <input type="checkbox"/> No			
Contact name			Telephone number
Owner's name and address		Home telephone	Work telephone
Lessor's name and address (if not owned)		Home telephone	Work telephone
Vehicle year	Make	Model	VIN number
		License plate number	Province of issue
Vehicle's current location		Area of damage	Estimate (\$)
Telephone number			
Description of damage/include cargo if applicable			
Current status of vehicle <input type="checkbox"/> Drivable <input type="checkbox"/> Towed from accident scene		Were there injuries in this vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and address of injured party			Telephone number
Name and address of medical provider			
Doctor's name	Telephone number	Medical attention given	

Additional vehicles and claimants should be listed on an additional reporting form. Please attach.

Witness Information

Name and address of a witness to the incident
Telephone number where witness can be reached

Additional Injury Information

Name and address of additional injured party			
Nature of injury	Body part	Party's telephone	Location <input type="checkbox"/> Insured's vehicle <input type="checkbox"/> Other vehicle <input type="checkbox"/> Pedestrian
Name and address of medical provider			
Doctor's name			Telephone number
Anything related to the incident you would like to add			

Privacy Statement: By submitting this information you are providing consent for the collection, use and disclosure of your personal information as may be necessary to access, investigate, and settle claims. Your personal information may be processed and stored by Zurich Insurance Company Ltd and its affiliates (collectively, “Zurich”) and authorized representatives, both in domestic and foreign jurisdictions outside Canada and is subject to applicable laws. Please contact the Zurich Privacy Officer if you require further additional information regarding the collection, use, disclosure, processing and storage of your personal information via email at privacy.zurich.canada@zurich.com or you can review our privacy statement at <https://www.zurichcanada.com/en-ca/about-zurich/privacy-statement>.

The above-named claimant may refuse to consent or withdraw their consent to the collection, storage, use or disclosure of personal information; however, the refusal to provide consent may result in Zurich being unable to offer and administer insurance coverage or prevent Zurich from being able to pay claim benefits.

Zurich is committed to protecting the privacy and confidentiality of information provided. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Zurich Insurance Company Ltd (Canadian Branch), 100 King Street West, Suite 5500, P.O. Box 290, Toronto, ON M5X 1C9

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