Weaver Insurance Agency Auto Liability Intake Form

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 ☐ No ☐		
Incident Information		
Date of Incident:	Time of Incident:	AM ☐ PM ☐
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 ☐ No ☐		
Injury Information		
Description of Injury		
Cause:	Body Part	
Nature:		
Medical Treatment Information		
Admitted to Hospital? Yes ☐ No ☐		
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Transportation Type: Select One		
Insured Vehicle Information		
Vehicle Fleet Number:		
VIN:		

Weaver & Weaver LLC
882 Lincoln Dr., Ste B
Sheridan, WY 82801
307-655-8001
claims@weaverinsagency.com

Weaver Insurance Agency Auto Liability Intake Form

Body Type:	Year:	Make:
Model:	Color:	
License Plate Number:	State:	
Damage Description:		
Estimated Damage:	Towed: Yes ☐ No ☐	
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 ☐ No ☐		
Injury Information		
Description of Injury		
Cause:	Body Part	
Nature:		
Medical Treatment Information		
Admitted to Hospital? Yes ☐ No ☐		
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 ☐	No ☐
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		

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Weaver Insurance Agency Auto Liability Intake Form

Carrier Name:	Phone Number:	
Injured Party Information		
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:	
Injury Information		
Injury Description:		
Cause:	Body Part:	
Nature:		
Medical Treatment Information		
Admitted to Hospital? Yes ☐ No ☐		
Facility Name:		
Street Address:		
City:	State:	Zip Code:
Phone:	Ext:	
Transportation Type: Select One		
Witness Information		
Name:		
Address:		
City:	State:	Zip Code:
Phone Number:		
Contact Information		
First Name:	MI:	Last Name:
Phone:	Ext:	Email Address:
Comments/Remarks:		

OFFICE USE ONLY:

Date Sent To Carrier: ______________________

Claim Adjuster Contact Information:
Name: ___________________________________
Phone: ___________________________________
Email: ___________________________________

Claim #: __________________________________

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