

Illinois Counties Risk Management Trust

Incident Reporting for All Claims Other than Workers Compensation

AUTOMOBILE ACCIDENTS

DATE COMPLETED: _____ DEPARTMENT _____

DEPARTMENT CONTACT _____

(Name and phone #)

ADDRESS/LOCATION OF INCIDENT: _____

DATE OF INCIDENT: _____ TIME OF INCIDENT: _____

POLICE DEPARTMENT: _____ REPORT #: _____

COUNTY VEHICLE? Yes ___ No ___ PERSONAL VEHICLE? Yes ___ No ___

Insurance Company: _____

COUNTY VEHICLE DESCRIPTION: - _____

(type of vehicle i.e vehicle #, year, make model)

COUNTY DRIVER: _____

OTHER PARTY OWNER: _____

(name, address, phone #)

OTHER DRIVER: _____

(If other than driver: name, address, phone #)

OTHER PARTY VEHICLE: _____

(Type of vehicle i.e year, make and model)

INJURED PARTY: _____

(name, address, phone)

TYPE OF INJURY: _____

WITNESSES/PASSENGERS: _____

DESCRIBE IN DETAIL WHAT HAPPENED: _____

PERSON COMPLETING: _____

**Send this form and any other related information to Insurance
Specialist, Administrative Services Department**