

# Auto Loss Report

Insured: **Tharco, Inc.** Contact Person: \_\_\_\_\_

Date of the Accident: \_\_\_/\_\_\_/\_\_\_ Time Accident Occurred: \_\_\_\_\_  
Contact Number: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**Accident Location:** Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

**Description of the Accident:** \_\_\_\_\_  
\_\_\_\_\_

Authority Contacted \_\_\_\_\_ Violations Cited? Yes No Report/Case # \_\_\_\_\_  
Insured Vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ VIN # \_\_\_\_\_  
Driver's Name: \_\_\_\_\_ License # \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_

**Describe the Damage:** \_\_\_\_\_  
\_\_\_\_\_

**Estimated loss amount:** \$ \_\_\_\_\_ When & Where the vehicle be seen: \_\_\_\_\_

## PROPERTY DAMAGE TO OTHER AUTO

Driver's Name: \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_  
Owner's Name (if different): \_\_\_\_\_ Home # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
Other Vehicle: Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ VIN # \_\_\_\_\_

**Describe the Damage:** \_\_\_\_\_  
\_\_\_\_\_

**Estimated loss amount:** \$ \_\_\_\_\_ When & Where the vehicle be seen: \_\_\_\_\_

## INJURIES

NAME & ADDRESS	PHONE #	EXTENT OF INJURIES
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_____	_____	_____
_____	_____	_____

## WITNESSES

Name _____	Phone # _____	Name _____	Phone # _____
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**Additional Remarks:** \_\_\_\_\_  
\_\_\_\_\_

**Reported By:** \_\_\_\_\_  
Fax or email this document to The Jacobs Company, Inc.

**sbrinlee@jacobscompany.com**  
**Fax # (301) 621-3043 or (410) 381-2105**  
**www.jacobscompany.com**