



**AUTO INFORMATIONAL CLAIM FORM**

Insured Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Accident Date: \_\_\_\_\_

**Employee Information**

*(Please list each employee involved)*

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Description of accident: \_\_\_\_\_  
*(Weather, cause, time, factors, etc.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Draw Diagram (if applicable):

**\*Please note this is an in office form for The Piedmont Group and for file purposes only\***

Fax or e-mail completed forms to (301) 865-9033 or [info@tpgins.net](mailto:info@tpgins.net).