Auto Liability Report of Incident

Carrier: Midwest Public Risk (MPR)
Claims Administrator (TPA): Thomas McGee, L.C.
(* = Required Information)

***MEMBER INFORMATION:**

PREPARER'S NAME	**PHONE:**
ENTITY	
LOCATION ADDRESS:	

***INCIDENT LOCATION INFORMATION:**

DATE OF ACCIDENT:		**TIME:**	
LOCATION:	**CITY:**	**STATE:**	**ZIP CODE:**
ACCIDENT / LOSS DESCRIPTION: *(BE AS DETAILED AS POSSIBLE)*			

***MEMBER INFORMATION/DRIVER/AUTO DAMAGE INFORMATION:**

MEMBER DRIVER NAME:		**ADDRESS:**	
DEPARTMENT:			
CONTACT PHONE:			
AUTO YEAR:	**MAKE:**	**MODEL:**	**COLOR:**
AUTO DAMAGE DESCRIPTION:			**ESTIMATED DAMAGE:**
INJURIES TO MEMBER?: ☐ **YES** ☐ **NO**			
MEMBER PASSENGERS: ☐ **YES** ☐ **NO**			
PASSENGER ADDRESS INFO:			

CLAIMANT VEHICLE INFORMATION:

DRIVER FIRST NAME:		**DRIVER LAST NAME:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**
HOME PHONE:		**CELL PHONE:**	
YEAR:	**MAKE:**	**MODEL:**	**COLOR:**
AUTO DAMAGE DESCRIPTION:			**ESTIMATED DAMAGE:**
WHERE CAN VEHICLE BE SEEN?			
WHEN CAN VEHICLE BE SEEN?			
INJURY DESCRIPTION:			
DID INJURED PERSON REQUIRE MEDICAL ATTENTION? ☐ **YES** ☐ **NO**			
HOSPITAL/CLINIC NAME:			
ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

E-mail completed form to claims@mprisk.org
Or Fax to 816-842-1276
Questions call 816-842-4800

CLAIMANT VEHICLE PASSENGER INFORMATION:

FIRST NAME:		LAST NAME:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:		CELL NUMBER:	
WAS THE PASSENGER INJURED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO			
INJURY DESCRIPTION:			
HOSPITAL/CLINIC NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:

CLAIMANT VEHICLE PASSENGER INFORMATION:

FIRST NAME:		LAST NAME:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	CELL NUMBER:		
WAS THE PASSENGER INJURED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO			
INJURY DESCRIPTION:			
HOSPITAL/CLINIC NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:

CLAIMANT VEHICLE PASSENGER INFORMATION:

FIRST NAME:		LAST NAME:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:	CELL NUMBER:		
WAS THE PASSENGER INJURED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO			
INJURY DESCRIPTION:			
HOSPITAL/CLINIC NAME:			
ADDRESS:	CITY:	STATE:	ZIP CODE:

WITNESS INFORMATION:

FIRST NAME:		LAST NAME:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE NUMBER:			
ARE THERE ADDITIONAL WITNESSES ASSOCIATED WITH THIS INCIDENT? ☐ YES ☐ NO			

POLICE INFORMATION:

REPORT WAS MADE TO POLICE? ☐ YES ☐ NO	CITATIONS? ☐ YES ☐ NO
DEPARTMENT NAME:	REPORT #:

COMMENTS/REMARKS:

REPORTED BY:	PHONE:

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