City of Largo Risk
Owner making claim for damage,
201 Highland Avenue, P. O. Box 296
Largo, FL 33779
(727) 587-6740 x7701
Incident / Accident Report

Management please:

- Answer all questions (PRINT or TYPE)
- Attach copies of incident bills, receipts, etc.
- Enter NA if section is not applicable

Name		**Date of Birth**					
Home Phone		**Work Phone**		**Cell Phone**			
Address		**City**		**State**		**Zip**	
Incident and/or Accident Information (Please list specific address or streets)							
Date		**Location**		**Time**			

Did you report incident or accident? ☒ **Yes** ☐ **No** **Date Reported**

If yes, to whom did you make the report?

Brief description of incident and/or accident.
Attach a diagram or additional information if needed.
Brief description of damage and/or injury from incident and/or accident:

Regarding this incident and/or accident, have you filed a claim with another insurance company? ☐ **Yes** ☐ **No**
If yes, please state the names and address of the company and the nature of such claims:

Nature of Claim	Insurance Company Information		
	Name	Address	Telephone

Has any insurance company paid or agreed to pay for any costs, fees or expenses related to this incident? ☐ **Yes** ☐ **No**
If yes, please specify the nature and amount of such payment.

Witness Contact Information
Please use another sheet of paper, if necessary.

Name	Address	City, State & Zip	Phone

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Have you ever filed a prior claim for damages from any other incident? ☐ Yes ☐ No

If yes, please state with whom, date, time and details of all prior claims.
Please use another sheet of paper, if necessary.

Claimant Name	Date / Time	Details

By typing or signing my name, I confirm all information provided is true and accurate.

Your Full Name		Date	

Incident and Accident Report

Please complete the following additional information for accident claims.

Your Driver's License	State		Number	
Are you a legal resident of Florida?	☐ Yes	☐ No	Are you Medicare Eligible?	☐ Yes ☐ No

Vehicle Involved in Accident			
Year	Make	Model	Color

Employer Information

Name		Telephone	
Address		City, State Zip	
Your Job Title		Your Average Weekly Pay	

Have you previously traveled in the area where the accident occurred? ☐ Yes ☐ No
If yes, describe frequency:

Total Amount of medical bills or expenses incurred:

Hospital and Physician Information
(Please use additional sheet of paper, if necessary)

Hospital		Physician	
Name		Name	
Address		Address	
Telephone		Telephone	

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Your Automobile Insurance Company Information

(Even if your vehicle was not included in the accident)

Name		**Telephone**	
Address		**City, State**	
Policy#		**Adjustor Name & No**	

Your Personal Physician (Family Doctor) Information

Name		**Telephone**	
Address		**City, State**	

Please list any previous injury / accidents

(Please use additional sheet of paper, if necessary)

Date		**City, State**	
Type of Injury		**Doctor**	
Claim #		**Ins. Adjuster**	
Ins Co Name		**Adjuster #**	

By typing or signing my name, I confirm all information provided is true and accurate.

Your Full Name		**Date**	

Additional Information

(Please use another sheet of paper, if necessary)