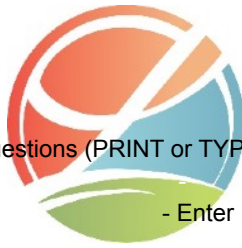


**City of Largo Risk Management  
for damage, please:  
Box 296  
Largo, FL 33779  
(727) 587-6740 x7701  
Incident / Accident Report**



- Answer all questions (PRINT or TYPE)

**Owner making claim  
201 Highland Avenue, P. O.**

- Attach copies of incident bills, receipts, etc.

- Enter NA if section is not applicable

<b>Name</b>		<b>Date of Birth</b>		<b>Social Security #</b>	
<b>Home Phone</b>		<b>Work Phone</b>		<b>Cell Phone</b>	
<b>Address</b>		<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Incident and/or Accident Information (Please list specific address or streets)</b>					
<b>Date</b>		<b>Location</b>		<b>Time</b>	

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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- Enter NA if section is not applicable

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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.

<b>Your Full Name</b>	<b>Date</b>
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**Incident and Accident Report**

**Please complete the following additional information for accident claims.**

<b>Your Driver's License</b>	<b>State</b>		<b>Number</b>	
<b>Are you a legal resident of Florida?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<b>Are you Medicare Eligible?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Vehicle Involved in Accident</b>				
<b>Year</b>	<b>Make</b>	<b>Model</b>	<b>Color</b>	

**Employer Information**

<b>Name</b>		<b>Telephone</b>	
<b>Address</b>		<b>City, State Zip</b>	
<b>Your Job Title</b>		<b>Your Average Weekly Pay</b>	

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

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

Hospital		Physician	
<b>Name</b>		<b>Name</b>	
<b>Address</b>		<b>Address</b>	
<b>Telephone</b>		<b>Telephone</b>	

**Your Automobile Insurance Company Information**

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

**City of Largo Risk Management  
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**Owner making claim  
201 Highland Avenue, P. O.**

- Answer all questions (PRINT or TYPE)

- Attach copies of incident bills, receipts, etc.

- Enter NA if section is not applicable

<b>Name</b>		<b>Telephone</b>	
<b>Address</b>		<b>City, State</b>	
<b>Policy#</b>		<b>Adjustor Name &amp; No</b>	

**Your Personal Physician (Family Doctor) Information**

<b>Name</b>		<b>Telephone</b>	
<b>Address</b>		<b>City, State</b>	

**Please list any previous injury / accidents**

(Please use additional sheet of paper, if necessary)

<b>Date</b>		<b>City, State</b>	
<b>Type of Injury</b>		<b>Doctor</b>	
<b>Claim #</b>		<b>Ins. Adjuster</b>	
<b>Ins Co Name</b>		<b>Adjuster #</b>	

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

<b>Your Full Name</b>		<b>Date</b>	
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**Additional Information**

(Please use another sheet of paper, if necessary)