Texas Council Risk Management Fund

Complete and Return to 5856TCRMF@sedgwick.com

ACCIDENT REPORT FORM
(Keep this form in your glove box and use it in case you have an accident.)

Complete both sides of this form to gather information at the accident scene that is required to document this accident. Make sure you document the other driver's information as well as list any passengers of the vehicles and witnesses to the accident. Submit the completed form to the individual in your center who is responsible for monitoring and reporting accidents to the Fund. If you have any questions or need assistance, contact the Fund during regular business hours (8AM to 5PM, Monday through Friday) at 1-800-580-6467.

1. MEMBER INFORMATION:

Member Name: _____ Contact Person: _____

Contact Phone Number: _____

Cost Code Number (if applicable): _____

Cost Code Name (if applicable): _____

2. ACCIDENT INFORMATION:

DATE OF LOSS (MM/DD/YY:)	TIME OF LOSS: ☐ AM ☐ PM	LOCATION OF ACCIDENT (Include City and State):
POLICE CONTACTED: Yes ☐ No ☐	OFFICER'S NAME:	POLICE REPORT NUMBER:
DESCRIPTION OF ACCIDENT: Were you ticketed? Yes ☐ No ☐ If yes, what was the ticket for?		

3. DESCRIBE WHAT HAPPENED:

4. YOUR VEHICLE INFORMATION:

YEAR:	MAKE:	MODEL:	VEHICLE IDENTIFICATION NUMBER (VIN):	LICENSE PLATE #:

DRIVER'S NAME:	DATE OF BIRTH (MM/DD/YY):	DRIVER'S LICENSE NUMBER & STATE:
DRIVER'S HOME ADDRESS:	DRIVER'S WORK PHONE:	DATE DRIVER HIRED:
	DRIVER'S HOME PHONE:	DATE LICENSE EXPIRES: (List restrictions in description of accident above.)
INJURIES: Yes ☐ No ☐ If yes, continue on back.	ADDRESS WHERE VEHICLE CAN BE INSPECTED:	

5. OTHER PARTY'S PROPERTY DAMAGE:

DESCRIPTION (If auto, indicate Year, Make, Model and VIN)	LICENSE PLATE #:	OTHER VEHICLE/ PROPERTY INSURED? Yes ☐ No ☐	COMPANY/AGENCY NAME:
OWNER'S NAME:	DATE OF BIRTH (MM/DD/YY):	DRIVER'S LICENSE NUMBER & STATE:	
OWNER'S ADDRESS:	WORK PHONE:	HOME PHONE:	
OTHER DRIVER'S NAME: (CHECK IF SAME AS OWNER) D	DRIVER'S LICENSE NUMBER & STATE:		
OTHER DRIVER'S ADDRESS:	WORK PHONE:	HOME PHONE:	
INJURIES: Yes ☐ No ☐ If yes, continue on back.	ADDRESS WHERE VEHICLE CAN BE INSPECTED:		

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6. INJURED INDIVIDUALS:

NAMES AND ADDRESS:	PHONE(S):	AGE:	LOCATION:	EXTENT OF INJURY:
	Home: Work:		☐ Pedestrian ☐ Insured Vehicle ☐ Other Vehicle	Describe: Initial Treatment:
	Home: Work:		☐ Pedestrian ☐ Insured Vehicle ☐ Other Vehicle	Describe: Initial Treatment:
	Home: Work:		☐ Pedestrian ☐ Insured Vehicle ☐ Other Vehicle	Describe: Initial Treatment:

7. WITNESSES OR PASSENGERS:

NAMES AND ADDRESS:	PHONE(S):	LOCATION:	DETAILS:
	Home: Work:	☐ Pedestrian ☐ Insured Vehicle ☐ Other Vehicle	
	Home: Work:	☐ Pedestrian ☐ Insured Vehicle ☐ Other Vehicle	

8.

Weather:	Surface:	Type:	Involved With:
☐ Clear	☐ Dry	☐ Head On	☐ Moving Vehicle
☐ Cloudy	☐ Wet	☐ Side Swipe	☐ Parked Vehicle
☐ Rain/Snow	☐ Snow/Ice	☐ Rear End	☐ Pedestrian
☐ Fog		☐ Side Impact	☐ Bike/Cycle
			☐ Animal
			☐ Fixed Object

Completed by: _____ Date: _____

Toll-Free Number for Automobile Claims
1-800-580-6467

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Revised 7/2024