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 P.O. BOX 1328  
 WATERLOO, IA 50704  
 PHONE: 844-898-2321  
 FAX: 855-313-6925

## AUTOMOBILE LOSS FORM

Please complete this form when reporting a claim or a possible claim. We will contact you for additional details. Claims can also be filed electronically using the "Report a Claim" feature on our website [vgminsurance.com](http://vgminsurance.com).

Insured Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

Contact Name \_\_\_\_\_

Contact Email \_\_\_\_\_ Phone \_\_\_\_\_

Insured's Physical Address \_\_\_\_\_

Insured's City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### INSURED'S VEHICLE

Driver Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Year \_\_\_\_\_ Make/Model \_\_\_\_\_ VIN# \_\_\_\_\_

### ACCIDENT INFORMATION

Address of Accident \_\_\_\_\_ City/State \_\_\_\_\_

Number of Vehicles Involved \_\_\_\_\_

Police Report Filed?  Yes  No Law Enforcement Agency \_\_\_\_\_

Report# \_\_\_\_\_ Phone \_\_\_\_\_

### Witnesses/Passengers

Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Description of Accident: \_\_\_\_\_

### OTHER DRIVER INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Year \_\_\_\_\_ Make/Model \_\_\_\_\_ VIN# \_\_\_\_\_

Injured?  Yes  No

Reported by: \_\_\_\_\_ Date: \_\_\_\_\_

Upon receipt, VGM Insurance Services will contact the appropriate carrier with these details and provide you with a claim number and adjuster information. Do not hesitate to contact us with questions.

### IMPORTANT NOTE

Please do not divulge any of this information to any party except VGM Insurance. Direct any inquiries from claimant, lawyers, manufacturers, etc. to our office.

Submit to: VGM Insurance Claims  
 Fax: 855-313-6925 or  
 Email: [claims@vgminsurance.com](mailto:claims@vgminsurance.com)