

Property Claim Report			
Named Insured:		Contact Name:	
Title / Position:		Contact Phone:	
Incident Information			
Date of Incident:		Time of Day Incident Occurred:	
Property Owner Name:		Cell Phone:	
Address:	City:	State:	Zip:
Estimated Repair Value:		Other insurance, if applicable:	
Please describe damage:			
Incident Type			
<input type="checkbox"/> Theft	<input type="checkbox"/> Vandalism	<input type="checkbox"/> Lightning	<input type="checkbox"/> Hail
<input type="checkbox"/> Fire	<input type="checkbox"/> Wind	<input type="checkbox"/> Other:	
Law Enforcement Agency contacted?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Department Name:		Report Number:	
Individual preparing this report:		Date:	
Signature:		Date:	

**Automobile Claim Report**

Date / Time of Loss:	Previously Reported:	Date of Report:
Name Insured:	Incident Number:	
Name Insured Contact Number:	Email Address:	

**Nature of Incident**

Incident Address:	City:	State:	Zip:
Law Enforcement Agency contacted?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what is the report number?			
Please describe the incident in detail:			

**Insured Vehicle / Employee Involved in Incident**

Vehicle Number:	Year / Make / Model of Vehicle:		
License State / Number:	Vehicle Identification Number:		
Vehicle Owner Name:	Cell Phone:		
Address:	City:	State:	Zip:
Driver Name / Employee ID:	Cell Phone:		
Address:	City:	State:	Zip:
Relation to company (position):	Purpose of Use:		
Employee Date of Birth:	Driver's License State / Number:		
Estimated Repair Value:	Other insurance, if applicable:		
Please describe damage:			

**Additional Vehicle / Property Damage**

Describe Property:	Company / Agency Policy Number:		
Property Owner Name:	Cell Phone:		
Address:	City:	State:	Zip:
Estimated Repair Value:	Other insurance, if applicable:		
Please describe damage:			

**Additional Vehicle / Property Damage**

Additional Individual Injured:	Cell Phone:		
Address:	City:	State:	Zip:
Additional Individual Injured:	Cell Phone:		
Address:	City:	State:	Zip:
Additional Individual Injured:	Cell Phone:		
Address:	City:	State:	Zip:

CLAIMS Fax: 214-749-7720 claims@ascendib.com



Witnesses			
Witness Name:		Cell Phone:	
Address:	City:	State:	Zip:
Witness Name:		Cell Phone:	
Address:	City:	State:	Zip:
Witness Name:		Cell Phone:	
Address:	City:	State:	Zip:

Individual preparing this report:		Date:
Signature:		Date:

**Property Claims**

Property Insurance Carrier:	Policy Number:
Effective Date:	Claims Reporting Hotline:

**Employee / Driver Responsibilities**

- The following actions should be taken Immediately:
  - Notify appropriate emergency personnel if necessary
  - Record as much detail about the incident (Property Claim Report attached).
  - Secure the names, addresses and contact information of all persons involved (persons using property/equipment; witnesses, etc.)
  - Notify the designated claims representative or your immediate supervisor.

**Designated Claims Representative or Supervisor Responsibilities**

- Immediately assess the incident report and arrange for repairs to the vehicle. Do not have the vehicle repaired until insurance claims adjuster has been contacted.