

Please keep this in your glove box.
Fill out and exchange information in case of accident.

Your Insurance Company: _____

Your Policy #: _____

Your Agent: _____

Repair Facility: _____

ADAMS COLLISION CENTER

Date of Accident: _____

Time of Accident: _____

Location: _____

Other Drivers Name: _____

Address: _____

City _____ State: _____ Zip Code: _____

Phone: _____

Yr., Make, Model of Vehicle: _____

License # _____

Drivers Licence # _____

Insurance Co. _____

Agent: _____

Policy #: _____

Witness 1: _____

Address: _____

City _____ State: _____ Zip Code: _____

Witness 2: _____

Address: _____

City _____ State: _____ Zip Code: _____

