Ph: 1-800-414-8784 / 559-842-5000
Email: claims@gurucommercial.com

Claim Form for all claims

Keep In Your Glove Box

POLICY HOLDER

Name:_____ Policy No:_____
Address:_____ Business Phone No:-_____

INSURED VEHICLE, DRIVER AND USE

Tractor-Bus: Year_____Make:_____Serial No:_____ Lic. No:_____Prov.:_____
Trailer- Bus: Year_____Make:_____Serial No:_____ Lic. No:_____Prov.:_____
Owner of Above Tractor:_____ Trailer:_____
Was equipment being operated about business of Assured:_____ Other Insurance Available:_____
Name of Driver:_____
Address:_____ Phone No:_____
_____ Age:_____
Driver's Licence No:_____ No. of Hours on Duty:_____

CARGO LOSS

Type of loss and commodity:_____ Bill of Lading Enclosed:
PresentLocation:_____ No_____ Yes_____

DETAILS OF ACCIDENT

Date:_____ 20_____Time:_____am/pm_____ WeatherConditions_____
Place:_____ Conditions of Road:_____
Police Report Made To:_____City - Officers Number_____ City orTown:_____
Any Charges Laid:_____ Province:_____
What Charge:_____ AgainstWhom:_____

DAMAGE TO VEHICLE OF POLICY HOLDER

COLLISION:_____FIRE:_____THEFT:_____ OTHER:_____

Present Location of Assured'sVehicle?_____ Truck:_____Tractor:_____
Assureds Estimate of Damage: _____ Trailer:_____Bus:_____
Can Assured Complete Repairs?_____Were Temporary Repairs Made:_____ Amount:_____

DAMAGE TO PROPERTY OF OTHERS

Owner of Vehicle:_____ Driver of Vehicle:_____
Address:_____ Year and Make of Vehicle:_____
Licence No:_____Phone_____ Licence No:_____
Damage:_____ Policy No:_____
Insurance Company:_____ Province:_____
Owner of Vehicle:_____ Driver of Vehicle:_____
Address:_____ Year and Make of Vehicle:_____
Licence No:_____Phone_____ Licence No:_____
Damage:_____ Policy No:_____
Insurance Company:_____ Province:_____

INJURED

(1)	(2)	(3)
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Phone:_____Age:_____	Phone:_____Age:_____	Phone:_____Age:_____
Injuries:_____	Injuries:_____	Injuries:_____
Doctor:_____	Doctor:_____	Doctor:_____
Hospital:_____	Hospital:_____	Hospital:_____

OCCUPANTS OF INSURED VEHICLE

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

OCCUPANTS OF OTHER VEHICLE:

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

IMPORTANT: INDEPENDENT WITNESSES: (Include names of bystanders who saw accident, or heard any statements made)

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

NAME:_____ ADDRESS:_____ PHONE:_____

THE ACCIDENT	POLICYHOLDER'S VEHICLE: SPEED: Before The Accident:_____km/h At Instant of Accident:_____per hour LIGHTS:_____ (ON - OFF - DIM - BRIGHT) Which Side of Road_____Warning:_____ Direction Travelled:_____	OTHER VEHICLE: SPEED: Before The Accident:_____km/h At Instant of Accident:_____per hour LIGHTS:_____ (ON - OFF - DIM - BRIGHT) Which Side of Road_____Warning:_____ Direction Travelled:_____

DRIVER'S STATEMENT OF HOW ACCIDENT OCCURRED:
PLEASE CIRCLE THE BOXES: File Auto Liab. claim: YES or NO File Physical Damage claim: YES or NO File Cargo Claim: YES or NO

What part of your vehicle and what part of other car were first in touch?_____

Whom do you consider is responsible?_____

Date Signed:_____Signature of Driver:_____

Date Reported:_____ How Reported:_____Phone:_____Wire:_____Letter:_____In Person:_____Time:_____

Attach a diagram to further explain accident, show points of compass, name of streets, direction of cars and position of cars at instant of accident