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Member Occurrence Report

For serious injury accidents call us 24/7 at 916-960-0900

IMPORTANT: This report must be completed for ALL occurrences on or involving insured vehicles, including passenger fall or other mishaps, and submitted by email or fax **within 24 hours of occurrence**. To complete the form online, use the tab key to move from one field to the next. When you are finished, click on the "Print" button at the bottom. **Fax the completed form to us.**

Member Information

Member Agency _____ Date _____
Contact Name _____ Policy # _____
Phone # _____ Fax # _____ Email _____
Driver Name _____ CADL# _____ Hire Date _____ DOB _____
Vehicle Make/Model _____ Year _____ VIN # (last 5 digits) _____
Describe damage to your vehicle _____
Defective Equipment? Brakes Steps WC Lift Tie Downs Door Seats Floor Other _____

Other (Adverse) Driver/Vehicle Info

Driver Name _____ License # _____ Phone # _____
Address _____
Vehicle Make/Model _____ Year _____ License # _____
Insurance Carrier _____ Policy # _____
Describe damage to other vehicle _____

Occurrence Information

Date _____ Time _____ AM PM
Location/Intersection _____
City/County/State _____
Area: Residential Commercial Rural Other _____
Pavement: Paved Gravel/Dirt Other _____ Wet Dry Other _____
Weather: Clear Rainy Cloudy Snow Fog Dust Other _____
Visibility: Daylight Dark Good Fair Poor

No. of occupants _____ Seatbelts used by driver? Yes No By passengers? Yes No Airbags deployed? Yes No No. of wheelchairs _____ W/C tie-downs in use? Yes No
Your vehicle: _____ Yes No Yes No Yes No _____ Yes No
Other vehicle: _____ Yes No Yes No Yes No
Posted Speed Limit: Your's _____ Other's _____ Intersection Traffic Controls (if applicable)
Speed of Travel: Your's _____ Other's _____ 1 way stop 3 way stop Traffic light RR crossing None
Direction of Travel: Your's _____ Other's _____ 2 way stop 4 way stop Yield Other _____

Police Report

Reporting Officer _____ Badge # _____ Report # _____

Dept (CHP, police, etc) _____ Citation issued? Your driver Other driver

Witnesses

Name _____	Phone # _____	Check if applicable <input type="checkbox"/> Your's <input type="checkbox"/> Other's
Name _____	Phone # _____	<input type="checkbox"/> Your's <input type="checkbox"/> Other's
Name _____	Phone # _____	<input type="checkbox"/> Your's <input type="checkbox"/> Other's
Name _____	Phone # _____	<input type="checkbox"/> Your's <input type="checkbox"/> Other's

Member Passenger Injuries

Name _____	Phone # _____	Check if applicable <input type="checkbox"/> Wheelchair <input type="checkbox"/> Boarding
Injury _____		<input type="checkbox"/> Fell <input type="checkbox"/> Debarking
Action Taken _____		

Name _____	Phone # _____	Check if applicable <input type="checkbox"/> Wheelchair <input type="checkbox"/> Boarding
Injury _____		<input type="checkbox"/> Fell <input type="checkbox"/> Debarking
Action Taken _____		

Name _____	Phone # _____	Check if applicable <input type="checkbox"/> Wheelchair <input type="checkbox"/> Boarding
Injury _____		<input type="checkbox"/> Fell <input type="checkbox"/> Debarking
Action Taken _____		

Other Driver/Passenger Injuries

Name _____	Phone # _____
Injury _____	
Action Taken _____	

Name _____	Phone # _____
Injury _____	
Action Taken _____	

Name _____	Phone # _____
Injury _____	
Action Taken _____	

Comments or Additional Information (witnesses, injuries, etc.)

Occurrence Description - Briefly tell exactly what happened. Remember to include *Who, What, When, Where, How, Why*. Indicate movement of involved vehicles when hazard first see. Indicate warnings or evasive actions taken. Describe length and position of any skid marks.

[Empty rectangular box for Occurrence Description]

Fax to: 916-783-7245

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