STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
DAVE JONES, INSURANCE COMMISSIONER

Consumer Services and Market Conduct Branch
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP
(213) 897-8921
www.insurance.ca.gov

AUTO BODY REPAIR SHOP REPORT FORM

Name of Automobile Body Repair Shop:			Business Phone:
Address:			Name of Reporting Person:
City:	State:	ZIP:	Position:

1. Complete name of insurance company involved:
2. Are you reporting a denial in an insurer's Direct Repair Program? Yes ____ No ____ If Yes, Skip to Question 8.
3. Type of Insurance: AUTO
4. Name and Address of the policyholder/claimant/customer:
5. Policy identification number:
6. Claim number:
7. Date loss occurred or began:
8. Name of Adjuster or Insurance Company Representative
9. Have you reported this to any other governmental agency? Yes____ No ____
   If yes, Please give the
   *Name of the Agency:*_____ *File number, if known:* _____
10. Have you prevoiusly written to the California Department of Insurance about this matter?
    Yes __ No __ File number (if available) _____ Date submitted _____

11. Briefly, describe the details of the transaction and provide any documentation to support your allegations.

_____
_____
_____
_____
_____
_____

_____ _____
Signature Date