

FedEx Ground Package System, Inc.  
ADJUSTER'S 48 HOUR FAX REPORT

TO: FedEx Ground  
Risk Management Dept.  
Liability Section  
Akron, OH  
FAX No.: 330-665-8522  
Number of Pages Faxed:  
Date Faxed: \_\_\_ / \_\_\_ / \_\_\_

FROM: Adjuster's Name  
Adjusting Co. Name  
Address (City & State):  
Telephone No.:  
FAX No.:  
Adjuster's File No.:

- FedEx Ground
- FedEx Ground, Ltd. (Canada)
- FedEx Home Delivery
- FedEx Supply Chain Services

**DIRECTIONS:** Please FAX this form to the Liability Section within 48 hours on ALL new assignments.  
**EXCEPTION: FATALITY OR SERIOUS PERSONAL INJURY** - Phone (do not FAX) the Liability Manager within 6 hours (refer to FedEx Ground's handling instructions). Please type or write legibly.

Our Driver's Name:

Source of Assignment (Individual's Name): \_\_\_\_\_ Phone #: \_\_\_\_\_

Acc. Date: \_\_\_ / \_\_\_ / \_\_\_ Time: \_\_\_ am/pm Date Assigned: \_\_\_ / \_\_\_ / \_\_\_ Time Assigned: \_\_\_ am/pm

Location: \_\_\_\_\_  
(Street or Hwy.) (City) (State)

Weather and Road Conditions:

Accident Description:

**DIAGRAM**

INDICATE NORTH BY ARROW

Our Vehicle:	Approx. PD
Tractor #: _____ Owner: _____	\$ _____
Trailer #: _____ Owner: _____	\$ _____
Trailer #: _____ Owner: _____	\$ _____
Van/Truck #: _____ Owner: _____	\$ _____
Company Car#: _____ Owner: _____	\$ _____

FedEx Ground	Cargo Aboard	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cargo Damage _____
FedEx Ground, Ltd.	Cargo Aboard	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cargo Damage _____
FedEx Home Delivery	<input type="checkbox"/> On Duty	<input type="checkbox"/> Off Duty		Cargo Damage _____
FedEx Supply Chain Services	<input type="checkbox"/> On Duty	<input type="checkbox"/> Off Duty		Cargo Damage _____

Is our Driver Injured? \_\_\_\_\_ Describe Injuries:

Vehicle #2:

Year and Make: \_\_\_\_\_ Approx. Property Damage \$ \_\_\_\_\_

Owner's Name:

Driver's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Have you obtained Veh. #2 Driver's Statement?  Yes  No (If yes,  Recorded  Signed)

Is Vehicle #2 Driver injured? \_\_\_\_\_ Describe Injuries:

Has Vehicle #2 Driver received medical treatment? \_\_\_\_\_ Admitted to Hospital?

(OVER) Please be certain you complete and FAX reverse side of this form.

ADJUSTER'S 48 HOUR FAX REPORT (Cont.)

Our Driver's Name: \_\_\_\_\_

Accident Location (State): \_\_\_\_\_

Accident Date: \_\_\_ / \_\_\_ / \_\_\_

<p><u>Vehicle #2 Passenger:</u>                      Passenger Name: _____ Age: _____                      Have you obtained a statement? <input type="checkbox"/> Recorded <input type="checkbox"/> Signed <input type="checkbox"/> None                      Is Vehicle #2 Passenger injured? _____ Describe injuries:                      Has Vehicle #2 Passenger received medical treatment? _____ Admitted to Hospital?</p>
<p><u>Additional Passenger:</u>                      Passenger Name: _____ Age: _____                      Have you obtained a statement? <input type="checkbox"/> Recorded <input type="checkbox"/> Signed <input type="checkbox"/> None                      Is Vehicle #2 Passenger injured? _____ Describe Injuries:                      Has Vehicle #2 passenger received medical treatment? _____ Admitted to Hospital?</p>
<p><u>Vehicle #3:</u>                      Year and Make: _____ Approx. Property Damage \$ _____                      Owner's Name: _____                      Driver's Name: _____ Age: _____                      Have you obtained Veh. #3 Driver's Statement? <input type="checkbox"/> Recorded <input type="checkbox"/> Signed <input type="checkbox"/> None                      Is Vehicle #3 Driver injured? _____ Describe Injuries:                      Has Vehicle #3 Driver received medical treatment? _____ Admitted to Hospital?</p>
<p><u>Additional Passenger:</u> <input type="checkbox"/> In Vehicle # _____ or <input type="checkbox"/> Pedestrian                      Name: _____ Age: _____                      Have you obtained a statement? <input type="checkbox"/> Recorded <input type="checkbox"/> Signed <input type="checkbox"/> None                      Injured? _____ Describe Injuries:                      Received medical treatment? _____ Admitted to Hospital?</p>
<p>Did police investigate? _____ Name of Police Agency: _____                      Any citations issued? <input type="checkbox"/> Yes <input type="checkbox"/> No To Whom: _____ Citation: _____                      Any witnesses? _____ Name: _____                      Have you obtained their statement? _____ Whom do witnesses favor?</p>
<p><u>Damage to Other Property:</u>                      Type of Property: _____                      Owner's Name: _____                      Damage Estimate: \$ _____ Describe Damage: _____</p>
<p>Adjuster's Comments:</p>     <p>Adjuster's Recommendations for Further Handling (be specific):</p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> <li>4.</li> </ol>

PLEASE KEEP THIS ORIGINAL IN YOUR FILE.