



# AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY	PHONE:	COMPANY	NAIC CODE:	MISCELLANEOUS INFO (Site & location code)			
POLICY NUMBER		POLICY TYPE		REFERENCE NUMBER		CAT#	
EFFECTIVE DATE		EXPIRATION DATE		DATE OF ACCIDENT		AND TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	
						PREVIOUSLY REPORTED <input type="checkbox"/> YES <input type="checkbox"/> NO	

## INSURED

## CONTACT

NAME AND ADDRESS		SOC SEC # OR FEIN:		NAME AND ADDRESS		WHERE TO CONTACT	
RESIDENCE PHONE (A/C, NO)		BUSINESS PHONE (A/C, NO, EXT)		RESIDENCE PHONE (A/C, NO)		BUSINESS PHONE (A/C, NO, EXT)	
						WHEN TO CONTACT	

## LOSS

LOCATION OF ACCIDENT (Include city & state)		AUTHORITY CONTACTED: REPORT #:		VIOLATIONS/CITATIONS	
DESCRIPTION OF ACCIDENT (Use separate sheet, if necessary)					

## POLICY INFORMATION

BODILY INJURY (Per Person)	BODILY INJURY (Per Accident)	PROPERTY DAMAGE	SINGLE LIMIT	MEDICAL PAYMENT	OTC DEDUCTIBLE	OTHER COVERAGE & DEDUCTIBLES (UM, no-fault, towing, etc)	
LOSS PAYEE					COLLISION DED		
UMBRELLA/ EXCESS <input type="checkbox"/>	UMBRELLA <input type="checkbox"/>	EXCESS CARRIER:		LIMITS:	AGGR	PER CLAIM/OCC	SIR/ DED

## INSURED VEHICLE

VEH#	YEAR	MAKE	BODY TYPE		PLATE NUMBER	STATE
		MODEL	V.I.N.			
OWNER'S NAME & ADDRESS				RESIDENCE PHONE (A/C, NO):		BUSINESS PHONE (AC, NO, EXT):
DRIVER'S NAME & ADDRESS <input type="checkbox"/> (Check if same as owner)				RESIDENCE PHONE (A/C, NO):		BUSINESS PHONE (AC, NO, EXT):
RELATION TO INSURED (Employee, family, etc.)	DATE OF BIRTH	DRIVER'S LICENSE NUMBER		STATE	PURPOSE OF USE	USED WITH PERMISSION? <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE DAMAGE	ESTIMATED AMOUNT	WHERE CAN VEHICLE BE SEEN?		WHEN CAN VEH BE SEEN?	OTHER INSURANCE ON VEHICLE	

## PROPERTY DAMAGED VEHICLE? YES NO

DESCRIBE PROPERTY (if auto, year, make, model, plate #)		OTHER VEH/PROP INS? <input type="checkbox"/> YES <input type="checkbox"/> NO		COMPANY OR AGENCY NAME: POLICY #:	
OWNER'S NAME & ADDRESS				RESIDENCE PHONE (A/C, NO):	
				BUSINESS PHONE (AC, NO, EXT):	
DRIVER'S NAME & ADDRESS <input type="checkbox"/> (Check if same as owner)				RESIDENCE PHONE (A/C, NO):	
				BUSINESS PHONE (AC, NO, EXT):	
DESCRIBE DAMAGE	ESTIMATED AMOUNT	WHERE CAN VEHICLE BE SEEN?			

## INJURED

NAME & ADDRESS	PHONE (A/C, NO)	PED	INS VEH	OTH VEH	AGE	EXTENT OF INJURY
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

## WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (A/C, NO)	INS VEH	OTH VEH	OTHER (Specify)
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

REMARKS (include Adjuster assigned)			
REPORTED BY	REPORTED TO	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER