



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	PREVIOUSLY REPORTED	
					<input type="checkbox"/> PM	<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 (A/C, NO, EXT):	
DRIVER'S NAME & ADDRESS <input type="checkbox"/> (Check if same as owner)			RESIDENCE PHONE (A/C, NO):		BUSINESS PHONE (A/C, 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?		Is Unit Drivable?	Has it Been Repaired?	

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 (A/C, NO, EXT):	
DRIVER'S NAME & ADDRESS <input type="checkbox"/> (Check if same as owner)			RESIDENCE PHONE (A/C, NO):	
			BUSINESS PHONE (A/C, 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 Criterion Claim Solutions	SIGNATURE OF INSURED	SIGNATURE OF PRODUCER
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