

# COMMONWEALTH OF VIRGINIA

## Automobile Loss Notice Form

**INJURY TO PEOPLE:** TELEPHONE IMMEDIATELY if possibility of injury exists (No matter how minor).

**DAMAGE TO PROPERTY:** IF SERIOUS, (Vehicle Disabled) TELEPHONE IMMEDIATELY

**OTHER:** If vehicle is insured for collision and disabled due to damage - TELEPHONE IMMEDIATELY.

If claim is under Comprehensive, Fire or Theft, only sections marked with \* need to be completed

**DO NOT DISCUSS ACCIDENT WITH ANY ONE EXCEPT COMPANY REPRESENTATIVE OR POLICE.**

<b>*POLICY-HOLDER</b>	NAME								
	ADDRESS:	STREET	CITY	STATE	ZIP CODE	PHONE NUMBER			
<b>*TIME AND PLACE OF ACCIDENT</b>	DATE OF ACCIDENT	HOUR	A.M. P.M.	LOCATION	STREET OR HIGHWAY	CITY	COUNTY	STATE	
	MAKE OF AUTO	YEAR	BODY TYPE	VEHICLE IDENTIFICATION NUMBER		IF TRAILER, SERIAL NUMBER			
<b>STATE AGENCY OR COMMUNITY SERVICES BOARD as Insureds USE ONLY</b>	NAME OF OWNER OR LEASING COMPANY			ADDRESS:	STREET	CITY	STATE	ZIP CODE	
	NAME OF DRIVER			ADDRESS:	STREET	CITY	STATE	ZIP CODE	
	DRIVER'S DATE OF BIRTH		DRIVER'S LICENSE NUMBER		WAS LICENSE IN EFFECT AT THE TIME OF ACCIDENT?				
	WAS AUTO BEING OPERATED FOR BUSINESS OR PLEASURE? <input type="checkbox"/> BUSINESS <input type="checkbox"/> PLEASURE			WHO GAVE PERMISSION?		WAS THE AUTO BEING USED FOR ERRAND FOR OWNER?			
	DESCRIBE PARTS DAMAGED AND EXTENT OF DAMAGE (NOTE: BY TERMS OF YOUR POLICY THE COMPANY MUST BE GIVEN REASONABLE OPPORTUNITY TO EXAMINE AUTO BEFORE REPAIRS ARE MADE) (IF GLASS DAMAGE, SEE REVERSE SIDE)								
	WHERE MAY AUTO BE SEEN?			ESTIMATED COST OF REPAIRS		WHERE IS THE VEHICLE NORMALLY GARAGED? (CITY & STATE)			
	MAKE OF AUTO		YEAR	LICENSE NUMBER	ESTIMATED COST OF REPAIRS				
<b>OTHER AUTO INVOLVED</b>	PARTS DAMAGED AND EXTENT OF DAMAGE								
	NAME OF OWNER			ADDRESS:	STREET	CITY	STATE	ZIP CODE	PHONE NUMBER
	NAME OF DRIVER			ADDRESS:	STREET	CITY	STATE	ZIP CODE	PHONE NUMBER
	IS AUTO INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF INSURANCE COMPANY						
<b>PASSENGERS</b>	NAMES OF PASSENGERS IN YOUR AUTO			ADDRESSES:	STREET	CITY	STATE	ZIP CODE	
	NAMES OF PASSENGERS IN OTHER AUTO			ADDRESSES:	STREET	CITY	STATE	ZIP CODE	
<b>INJURIES (No Matter How Minor)</b>	NAMES OF PERSONS INJURED			ADDRESSES			INJURIES	AGE	
	IN WHICH AUTO WERE INJURED RIDING								
NAME OF DOCTOR OR HOSPITAL			ADDRESS:	STREET	CITY	STATE	ZIP CODE		

PROPERTY DAMAGE OTHER THAN AUTO	NAME OF OWNER		ADDRESS: STREET		CITY	STATE	ZIP CODE	
	KIND OF PROPERTY							
	ESTIMATED COST OF REPAIR		WHERE MAY PROPERTY BE SEEN?					
*WITNESSES	NAMES		ADDRESSES: STREET		CITY	STATE	ZIP CODE	PHONE NUMBERS
DESCRIP- TION OF ACCIDENT	ON WHAT STREET OR ROAD WERE YOU DRIVING?		DIRECTION	SPEED	STREET OR ROAD OTHER AUTO WAS DRIVING ON?		DIRECTION	SPEED
	WERE YOUR LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM		WERE THE OTHER AUTO'S LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM		WHAT TRAFFIC CONTROLS?		FOR WHOM?	SPEED LIMIT
	DID EITHER DRIVER GIVE SIGNAL OF ANY KIND? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHO?			IF INTERSECTION, WHO ENTERED FIRST?		WHO HAD RIGHT OF WAY?		
	WHICH DRIVER VIOLATED TRAFFIC ORDINANCE?		CHARGE:		DID POLICE INVESTIGATE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		POLICE ADDRESS?	
	DESCRIBE, IN YOUR OWN WORDS, HOW ACCIDENT HAPPENED:							
	SHOW ON THE DIAGRAM THE POSITION OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTHER OBJECTS, SHOW STREET NAMES							
*GLASS BREAKAGE	NOTE: By terms of your policy, the company must be given reasonable opportunity to examine auto before repairs are made.							
	LOCATION OF BREAKAGE <input type="checkbox"/> DOOR <input type="checkbox"/> VENT <input type="checkbox"/> REAR <input type="checkbox"/> WINDSHIELD <input type="checkbox"/> OTHER, DESCRIBE							
	TYPE OF GLASS <input type="checkbox"/> TINTED <input type="checkbox"/> SAFETY <input type="checkbox"/> CLEAR <input type="checkbox"/> PLATE		TYPE OF BREAK <input type="checkbox"/> CRACKED <input type="checkbox"/> CHIPPED OR PITTED <input type="checkbox"/> SHATTERED <input type="checkbox"/> BULL'S EYE (⊙) <input type="checkbox"/> HALF MOON (☾)					
WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION ON DIAGRAM:								
DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN				BY WHOM?				
DATE OF REPORT				SIGNATURE				