LOSS FORM

So that we may properly evaluate your loss, please complete the "General" information section and any following sections that apply. Please be as descriptive as possible and attach additional pages, if necessary. This form is for administrative purposes only and should not be construed as legal advice. Completion of this form does not imply that you will be compensated for your loss or that the Road Commission is liable for any asserted damages. This form does not constitute, substitute for, or replace any legal notice required by any statute or law in the State of Michigan, whether contained in the Governmental Tort Liability Act, MCL 691.1401, et seq., or otherwise. By accepting this form, the Road Commission does not waive any defense available to it under the laws of the State of Michigan.

GENERAL

NAME: _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____ **PHONE: (HOME):** _____ **(WORK):** _____

COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED: _____

IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER: _____

DATE & TIME OF ACCIDENT/INCIDENT: _____

LOCATION OF ACCIDENT/INCIDENT: _____

POLICE NOTIFICATION? YES _____ **NO** _____ **COMPLAINT NUMBER:** _____

DESCRIPTION OF ACCIDENT/INCIDENT: _____

_____

_____

WITNESSES: YES _____ **NO** _____ **(If so, provide name, address, and telephone numbers on back of this form.)**

INJURY

INJURED? YES _____ **NO** _____ **(If yes, please describe):** _____

_____

_____

MEDICAL FACILITY PROVIDING TREATMENT: _____

ARE YOU TREATING NOW? YES _____ **NO** _____

HAVE YOU LOST ANY TIME FROM WORK?: YES _____ **NO** _____ **(If yes, how long?):** _____

NAME, ADDRESS, PHONE NUMBER OF EMPLOYER: _____

_____

DATE RETURNING TO WORK: _____

AUTO

AUTOMOBILE INVOLVED: MAKE: _____ **MODEL:** _____ **YEAR:** _____

DESCRIBE DAMAGE: _____

_____

ATTACH (2) ESTIMATES: SHOP #1 EST. $ _____ **SHOP #2 EST. $** _____

AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier): _

_____

AGENT'S NAME: _____ **POLICY #:** _____

COLLISION COVERAGE: YES: _____ **NO:** _____ **DEDUCTIBLE $** _____

COMPREHENSIVE COVERAGE: YES: _____ **NO:** _____ **DEDUCTIBLE $** _____

HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES: _____ **NO:** _____

IS THERE A LIEN ON THIS VEHICLE?: YES: _____ **NO:** _____

PROPERTY

DESCRIBE PROPERTY DAMAGE: _____

_____

ATTACH (2) ESTIMATES: EST. #1 $ _____ **EST. #2 $** _____

HOMEOWNER'S/COMMERCIALPROPERTY COVERAGE: YES _____ **NO** _____ **DEDUCTIBLE $** _____

INSURANCE CARRIER: _____

NAME, ADDRESS, PHONE NUMBER & AGENT'S NAME: _____

_____ **POLICY #:** _____

SIGNATURE: _____ DATE: _____
(Required)

NOTE: A police report and a copy of your insurance declaration page (showing policy dates and coverages pertinent to loss date) are required, if applicable. Failure to provide the information requested on this form will cause delay in the processing of your loss. Please allow 30 days for processing.