



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
RISK MANAGEMENT SECTION
AUTOMOBILE LOSS NOTICE

**RISK MANAGEMENT SECTION
OFFICE OF ADMINISTRATION
P.O. BOX 809
JEFFERSON CITY, MISSOURI 65102
TELEPHONE NUMBER (573) 751-4044
FAX NUMBER (573) 751-7819**

This form **must be completed** for the Risk Management office to start a file. Please complete and **fax or mail** this form to Risk Management within 24-48 hours of the accident. **PLEASE PRINT CLEARLY OR TYPE.**

REMARKS	FOR OFFICE USE ONLY
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REPORTING AGENCY

STATE DEPARTMENT			PERSON TO CONTACT FOR QUESTIONS REGARDING THIS CLAIM		
ADDRESS			NAME _____		
CITY	STATE	ZIP CODE	CONTACT'S BUSINESS PHONE (A/C, NO., EXT.) _____		
SAM II AGENCY NUMBER		SAM II ORG NUMBER	AGENCY PHONE (A/C, NUMBER) _____		

ACCIDENT INFORMATION

LOCATION OF ACCIDENT (INCLUDING CITY & STATE)			POLICE CONTACTED (Y/N) AND REPORT NO.		VIOLATIONS/CITATIONS
DATE (MM/DD/YY) & TIME OF LOSS		PREVIOUSLY REPORTED	DESCRIPTION OF ACCIDENT (USE REVERSE SIDE, IF NECESSARY) THIS IS REQUIRED.		
	A.M.	YES			
	P.M.	NO			

STATE VEHICLE INFORMATION

YEAR	MAKE	MODEL	V.I.N. (VEHICLE IDENTIFICATION)	PLATE NUMBER
OWNER'S NAME AND ADDRESS				PHONE (A/C, NO., EXT.)
DRIVER'S NAME AND ADDRESS (CHECK IF STATE EMPLOYEE) <input type="checkbox"/>			DRIVER'S SOCIAL SECURITY # REQUIRED	BUSINESS PHONE (A/C, NO., EXT.)
RELATION TO INSURED (EMPLOYEE, FAMILY, ETC.)	DATE OF BIRTH	PURPOSE OF USE	DID THE ACCIDENT OCCUR IN A LOCATION ALONG A ROUTE CONSISTENT WITH THIS PURPOSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	USED WITH PERMISSION <input type="checkbox"/> YES <input type="checkbox"/> NO
DESCRIBE DAMAGE	ESTIMATE AMOUNT \$	WHERE CAN VEHICLE BE SEEN	OTHER INSURANCE ON VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO	

OTHER VEHICLE INVOLVED OR PROPERTY DAMAGED IN ACCIDENT

DESCRIBE PROPERTY (IF AUTO, YEAR, MAKE, MODEL, PLATE NO.)		OTHER VEH. OR PROP. INSURED <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY OR AGENCY NAME AND POLICY NUMBER		
OWNER'S NAME AND ADDRESS		BUSINESS PHONE (A/C, NO., EXT.)	RESIDENCE PHONE (A/C, NO.)		
OTHER DRIVER'S NAME AND ADDRESS (CHECK IF SAME AS OWNER) <input type="checkbox"/>		BUSINESS PHONE (A/C, NO., EXT.)	RESIDENCE PHONE (A/C, NO.)		
DESCRIBE DAMAGE	ESTIMATE AMOUNT \$	WHERE CAN DAMAGE BE SEEN			

INJURED

NAME AND ADDRESS	PHONE (A/C, NO.)	PED	INS. VEH.	OTHER VEH.	AGE	EXTENT OF INJURY

WITNESSES OR PASSENGERS

NAME AND ADDRESS	PHONE (A/C, NO.)	INS. VEH.	OTHER VEH.	OTHER (SPECIFY)

FORM COMPLETED BY (PLEASE PRINT)	SIGNATURE
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