

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.

G E N E R A L	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.)
I N J U R Y	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: _____
A U T O	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: _____
P R O P E R T Y	DESCRIBE PROPERTY DAMAGE: _____ _____ ATTACH (2) ESTIMATES: EST. #1 \$ _____ EST. #2 \$ _____ HOMEOWNER'S/COMMERCIAL PROPERTY 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.