AUTOMOBILE LOSS NOTICE

Central California Conference of SDA
2820 Willow Avenue, Clovis, CA 93612
OFFICE: (559) 347-3000
Submit Completed Form to: propandriskmgmt@cccsda.org

▷ INSURED:

CHURCH, SCHOOL OR OTHER: | CONTACT NAME: | CONTACT - HOME PHONE:
CONFERENCE/MISSION: | CONTACT EMAIL: | CONTACT - WORK PHONE:

▷ LOSS INFORMATION:

MONTH	DAY	YEAR	TIME
			AM PM

LOCATION OF ACCIDENT - ADDRESS: | CITY: | STATE: | ZIP CODE:
DATE REPORTED TO POLICE *(MM/DD/YYYY)*: | POLICE REPORT NUMBER: | VIOLATIONS / CITATIONS:
DESCRIPTION OF ACCIDENT/NATURE OF ACTIVITY *(USE ADDITIONAL SHEET IF NECESSARY)*

▷ INSURED VEHICLE:

YEAR, MAKE, MODEL: | V.I.N. (LAST 5 DIGITS OF ID#):
OWNER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:
ADDRESS: | CITY: | STATE: | ZIP CODE:

DRIVER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:
ADDRESS: | CITY: | STATE: | ZIP CODE:
RELATIONSHIP TO INSURED: | DATE OF BIRTH: | PURPOSE OF VEHICLE USE: | WAS DRIVER INJURED? **YES** **NO**
DESCRIBE DAMAGE: | USED WITH PERMISSION? **YES** **NO**
ESTIMATE AMOUNT: | WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ DAMAGED PROPERTY: *FOR VEHICLE INFORMATION OTHER THAN ABOVE*

DESCRIBE PROPERTY (IF AUTO: YEAR, MAKE, MODEL, PLATE NO):
INSURANCE COMPANY OR AGENCY NAME & POLICY # (IF ANY):
OWNER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:
ADDRESS: | CITY: | STATE: | ZIP CODE:

DRIVER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:
ADDRESS: | CITY: | STATE: | ZIP CODE:
DESCRIBE DAMAGE: | ESTIMATE AMOUNT:
WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE: | WAS DRIVER INJURED? **YES** **NO**

▷ PASSENGERS: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? **YES** **NO**
ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? **YES** **NO**
ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? **YES** **NO**
ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ WITNESSES: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER:
ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER:
ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ INCIDENT REPORTED BY: | DATE (MM/DD/YYYY):
▷ LOSS NOTICE COMPLETED BY: | DATE (MM/DD/YYYY):
▷ SIGNATURE OF INSURED'S AUTHORIZED REPRESENTATIVE: | DATE OF SIGNING (MM/DD/YYYY):

(Form Date: 03/28/2014)