

# 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.**

*POLICY-HOLDER	NAME <b>James Madison University</b>					POLICY NUMBER <b>C-900093</b>		
	ADDRESS: STREET <b>1041 S. Main St., MSC 5725</b>		CITY <b>Harrisonburg</b>		STATE <b>VA</b>	ZIP CODE <b>22807</b>	PHONE NUMBER <b>(540) 568-7701</b>	
*TIME AND PLACE OF ACCIDENT	DATE OF ACCIDENT		HOUR A.M. P.M.	LOCATION STREET OR HIGHWAY		CITY	COUNTY STATE	
STATE AGENCY OR COMMUNITY SERVICES BOARD as insureds USE ONLY	MAKE OF AUTO	YEAR	BODY TYPE		VEHICLE IDENTIFICATION NUMBER		IF TRAILER, SERIAL NUMBER	
	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)		
OTHER AUTO INVOLVED	MAKE OF AUTO	YEAR	LICENSE NUMBER		ESTIMATED COST OF REPAIRS			
	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					
PASSENGERS	NAMES OF PASSENGERS IN YOUR AUTO			ADDRESSES: STREET CITY STATE ZIP CODE				
	NAMES OF PASSENGERS IN OTHER AUTO			ADDRESSES: STREET CITY STATE ZIP CODE				
INJURIES (No Matter How Minor)	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			
DESCRIPTION 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													
	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"/> SHATTERED <input type="checkbox"/> CHIPPED OR PITTED <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									