

# AUTOMOBILE ACCIDENT OR LOSS NOTICE



### STATE EMPLOYEE INFORMATION

Department:	Address:	Phone:
Date/Time of Accident:	Location:	
Make/Model of Vehicle:	Year:	Registration No.:
Driver Name:	Work Address:	Work Phone:

### CLAIMANT INFORMATION

Driver Name:	DOB:	SSN:
Date/Time of Accident:	Location:	
Home Phone:	Work Phone:	Cell Phone:
Address:		
Vehicle Owner:	Work Phone:	Home/Cell Phone:
Address:		
Make/Model of Vehicle:	Year:	Registration No.:
Insurance Carrier:	Phone:	Policy No.:

### INJURED PARTIES

Name:	Address:		
Home Phone:	Work Phone:	Cell Phone:	
Taken to Hospital From Scene: Yes No		What Hospital:	
Was Follow-up Treatment Required: Yes No		Name/Address of Care Provider:	
Brief Description of Injuries Sustained:			
Name:	Address:		
Home Phone:	Work Phone:	Cell Phone:	
Taken to Hospital From Scene: Yes No		What Hospital:	
Was Follow-up Treatment Required: Yes No		Name/Address of Care Provider:	
Brief Description of Injuries Sustained:			

### WITNESSES

Name/Address/Phone:
Name/Address/Phone:

### INCIDENT DESCRIPTION (Please continue on separate sheet if needed.)

What Drivers Intended To Do: (Check one for each driver)

Driver			Driver		
1	2	3	1	2	3
Go straight Ahead			Start in Traffic		
Overtake and Pass			Start from Parked Position		
Make Right Turn			Back-up		
Make Left Turn			Remain Stopped in Traffic		
Make U Turn			Remain Parked		
Make Right Turn			Get Out of Parked or Stopped Vehicle		
Direction of Travel/Side of Street:			Lights On: Yes No		Signal Given: Yes No
Weather at Time of Accident:			Condition of Road:		
Were The Police Notified: Yes No			City/Town:		Police Report No.:

### Drivers Description of Accident or Loss (PLEASE USE PAGE 2 IF NEEDED)

Preparer:	Date:
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State of Vermont  
Office of Risk Management  
6 Baldwin St.  
Montpelier, VT 05633-3801  
(802) 828-2899 PHONE - (802) 828-0410 FAX  
Sov.riskhelp@state.vt.us

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