



# AUTOMOBILE LOSS NOTICE

12501 Old Columbia Pike - Silver Spring, MD 20904

OFFICE: (301) 680-6870 | FAX: (301) 680-6878

EMAIL: claims@adventistrisk.org

▷ **INSURED:**

CHURCH, SCHOOL OR OTHER:  
CONFERENCE/MISSION:

CONTACT NAME:  
CONTACT EMAIL:

CONTACT - HOME PHONE:  
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:	M.I.		LAST NAME:	V.I.N. (LAST 5 DIGITS OF ID#):	EMAIL ADDRESS:	CITY:	STATE:	ZIP CODE:
OWNER - FIRST NAME:	M.I.		LAST NAME:	EMAIL ADDRESS:	CITY:	STATE:	ZIP CODE:	
ADDRESS:	M.I.		LAST NAME:	EMAIL ADDRESS:	CITY:	STATE:	ZIP CODE:	
DRIVER - FIRST NAME:	M.I.		LAST NAME:	EMAIL ADDRESS:	CITY:	STATE:	ZIP CODE:	
ADDRESS:	M.I.		LAST NAME:	EMAIL ADDRESS:	CITY:	STATE:	ZIP CODE:	
RELATIONSHIP TO INSURED:	DATE OF BIRTH: (MM/DD/YYYY)		PURPOSE OF VEHICLE USE:		WAS DRIVER INJURED?	YES	NO	
DESCRIBE DAMAGE:	WHERE CAN VEHICLE BE SEEN? - ADDRESS:		CITY:	STATE:	ZIP CODE:	WAS DRIVER INJURED?	YES	NO
ESTIMATE AMOUNT:	WHERE CAN VEHICLE BE SEEN? - ADDRESS:		CITY:	STATE:	ZIP CODE:	USED WITH PERMISSION?	YES	NO

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

▷ **PASSENGERS:** USE ADDITIONAL SHEETS IF NECESSARY

NAME:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO
ADDRESS:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO
NAME:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO
ADDRESS:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO
NAME:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO
ADDRESS:	M.I.	LAST NAME:	PHONE NUMBER:	INJURED?	YES	NO

▷ **WITNESSES:** USE ADDITIONAL SHEETS IF NECESSARY

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