Policy#: ______________
Expiration Date: ________

AUTOMOBILE LOSS NOTICE

*Required Field

*MEMBER/NAME AND ADDRESS: ____

PHONE: ____

*DATE AND TIME OF LOSS: ____

*LOCATION OF LOSS: ____
(INCLUDE CITY/STATE)

*FACTS OF THE ACCIDENT: ____

AUTHORITY CONTACTED: ________________________ REPT #: ______________

YOUR VEHICLE: YEAR________ MAKE____________ * VIN#: ____________________

DRIVER ________________________ PHONE #: ________________________

DRIVERS RELATIONSHIP TO INSURED: ________________________________

WAS DRIVER WORKING AT TIME OF LOSS: ________________________________

DESCRIBE DAMAGE TO ASSURED VEHICLE: ________________________________

WHERE CAN VEHICLE BE SEEN: ____

OWNER OF THE OTHER VEHICLE OR PROPERTY: ____________________________
(INCLUDE NAME/ADDRESS/PHONE)

DRIVER OF OTHER VEHICLE: ____

DRIVER OF OTHER VEHICLE INSURANCE COMPANY: __________________________

WHAT TYPE OF VEHICLE IS IT: ____

DESCRIBE DAMAGE TO OTHER VEHICLE: ________________________________

INJURIES: ____

WITNESSES/PASSENGERS: ____

*REPORTED BY: ____________________ * PHONE#: ______________ *DATE: ____________

Once form is completed:

- EMAIL COMPLETED FORM TO CATHOLIC MUTUAL GROUP AT REPORTACLAIM@CATHOLICMUTUAL.ORG
  - INCLUDE ANY PICTURES OF THE ACCIDENT AREA AND DAMAGE OCCURRED WHEN SUBMITTING FORM.
- NOTIFY THE DOSP INSURANCE & RISK MANAGEMENT OFFICE BY EMAILING FORM TO VCB@DOSP.ORG OR FAX 727-374-0214
- ALL CLAIMS SHOULD BE REPORTED WITHIN 48 HOURS OF OCCURRENCE.