CLAIM FORM

So that we may properly evaluate your claim, please complete the "General" information section and any following sections that apply. Please be as descriptive as possible. (Completion of this form does not imply that your claim will be paid or that the Road Commission is liable for your damages.) Please mail your claim to: Claims Department, PO Box 15067, Lansing, MI 48901

GENERAL

NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE: (HOME): _____ (WORK): _____

COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED: _____

IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER: _____

DATE & TIME OF ACCIDENT/INCIDENT: _____

LOCATION OF ACCIDENT/INCIDENT: _____

POLICE NOTIFICATION? YES _____ NO _____ COMPLAINT NUMBER: _____

DESCRIPTION OF ACCIDENT/INCIDENT: _____

_____

_____

WITNESSES: YES _____ NO _____ (If so, provide name, address, and telephone numbers on back of this form.)

INJURY

INJURED? YES _____ NO _____ (If yes, please describe): _____

_____

_____

MEDICAL FACILITY PROVIDING TREATMENT: _____

ARE YOU TREATING NOW? YES _____ NO _____

HAVE YOU LOST ANY TIME FROM WORK?: YES _____ NO _____ (If yes, how long?): _____

NAME, ADDRESS, PHONE NUMBER OF EMPLOYER: _____

_____

DATE RETURNING TO WORK: _____

AUTO

AUTOMOBILE INVOLVED: MAKE: _____ MODEL: _____ YEAR: _____

DESCRIBE DAMAGE: _____

_____

ATTACH (2) ESTIMATES: SHOP #1 EST. $ _____ SHOP #2 EST. $ _____

AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier): _

_____

AGENT'S NAME: _____ POLICY #: _____

COLLISION COVERAGE: YES: _____ NO: _____ DEDUCTIBLE $ _____

COMPREHENSIVE COVERAGE: YES: _____ NO: _____ DEDUCTIBLE $ _____

HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES: _____ NO: _____

IS THERE A LIEN ON THIS VEHICLE?: YES: _____ NO: _____

PROPERTY

DESCRIBE PROPERTY DAMAGE: _____

_____

ATTACH (2) ESTIMATES: EST. #1 $ _____ EST. #2 $ _____

HOMEOWNER'S/COMMERCIALPROPERTY COVERAGE: YES ____ NO____ DEDUCTIBLE $ _____

INSURANCE CARRIER: _____

NAME, ADDRESS, PHONE NUMBER & AGENT'S NAME: _____

_____ POLICY #: _____

SIGNATURE: _____ DATE: _____
(Required)

NOTE: A police report and a copy of your insurance declaration page (showing policy dates and coverages pertinent to accident date) are required if applicable to your claim. Information requested on this form that you fail to provide will cause delay in the processing of your claim. Please allow 3 to 4 weeks for handling of this claim. If you have questions regarding receipt of your claim, please call Sedgwick Claims at 262-785-4358.