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.