

# LOSS FORM

So that we may properly evaluate your loss, please complete the "General" information section and any following sections that apply. Please be as descriptive as possible and attach additional pages, if necessary. This form is for administrative purposes only and should not be construed as legal advice. Completion of this form does not imply that you will be compensated for your loss or that the Road Commission is liable for any asserted damages. This form does not constitute, substitute for, or replace any legal notice required by any statute or law in the State of Michigan, whether contained in the Governmental Tort Liability Act, MCL 691.1401, et seq., or otherwise. By accepting this form, the Road Commission does not waive any defense available to it under the laws of the State of Michigan.

<b>G E N E R A L</b>	<b>NAME:</b> _____ <b>ADDRESS:</b> _____ <b>CITY:</b> _____ <b>STATE:</b> _____ <b>ZIP CODE:</b> _____ <b>PHONE: (HOME):</b> _____ <b>(WORK):</b> _____ <b>COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED:</b> _____ <b>IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER:</b> _____ <b>DATE &amp; TIME OF ACCIDENT/INCIDENT:</b> _____ <b>LOCATION OF ACCIDENT/INCIDENT:</b> _____ <b>POLICE NOTIFICATION? YES</b> _____ <b>NO</b> _____ <b>COMPLAINT NUMBER:</b> _____ <b>DESCRIPTION OF ACCIDENT/INCIDENT:</b> _____ _____ <b>WITNESSES: YES</b> _____ <b>NO</b> _____ (If so, provide name, address, and telephone numbers on back of this form.)
<b>I N J U R Y</b>	<b>INJURED? YES</b> _____ <b>NO</b> _____ (If yes, please describe): _____ _____ <b>MEDICAL FACILITY PROVIDING TREATMENT:</b> _____ <b>ARE YOU TREATING NOW? YES</b> _____ <b>NO</b> _____ <b>HAVE YOU LOST ANY TIME FROM WORK?: YES</b> _____ <b>NO</b> _____ (If yes, how long?): _____ <b>NAME, ADDRESS, PHONE NUMBER OF EMPLOYER:</b> _____ _____ <b>DATE RETURNING TO WORK:</b> _____
<b>A U T O</b>	<b>AUTOMOBILE INVOLVED: MAKE:</b> _____ <b>MODEL:</b> _____ <b>YEAR:</b> _____ <b>DESCRIBE DAMAGE:</b> _____ _____ <b>ATTACH (2) ESTIMATES: SHOP #1 EST. \$</b> _____ <b>SHOP #2 EST. \$</b> _____ <b>AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier):</b> _____ _____ <b>AGENT'S NAME:</b> _____ <b>POLICY #:</b> _____ <b>COLLISION COVERAGE: YES:</b> _____ <b>NO:</b> _____ <b>DEDUCTIBLE \$</b> _____ <b>COMPREHENSIVE COVERAGE: YES:</b> _____ <b>NO:</b> _____ <b>DEDUCTIBLE \$</b> _____ <b>HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES:</b> _____ <b>NO:</b> _____ <b>IS THERE A LIEN ON THIS VEHICLE?: YES:</b> _____ <b>NO:</b> _____
<b>P R O P E R T Y</b>	<b>DESCRIBE PROPERTY DAMAGE:</b> _____ _____ <b>ATTACH (2) ESTIMATES: EST. #1 \$</b> _____ <b>EST. #2 \$</b> _____ <b>HOMEOWNER'S/COMMERCIAL PROPERTY COVERAGE: YES</b> _____ <b>NO</b> _____ <b>DEDUCTIBLE \$</b> _____ <b>INSURANCE CARRIER:</b> _____ <b>NAME, ADDRESS, PHONE NUMBER &amp; AGENT'S NAME:</b> _____ _____ <b>POLICY #:</b> _____

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
 (Required)

NOTE: A police report and a copy of your insurance declaration page (showing policy dates and coverages pertinent to loss date) are required, if applicable. Failure to provide the information requested on this form will cause delay in the processing of your loss. Please allow 30 days for processing.