NATIONAL CLAIMS MANAGEMENT **AUTOMOBILE LOSS NOTICE** **Fax: 503-636-1605**			Date Reported
Agent Agent Fax:	Agent Phone Policy Number Date of Accident	Company Effective Date Time of Accident ☐ a.m. ☐ p.m.	Reported by: Expiration Date Previously Reported ☐ Yes ☐ No

INSURED

CONTACT

Name and Address		Name		Where to Contact
Residence Phone	Business Phone	Cell Phone	Business Phone	Fax Number

LOSS

Location ofAccident	Authority Contacted:	Report #:	Violations/Citations
Description of Accident:			

POLICY INFORMATION

B I per person	B I per accident	Property Damage	Single Limit	Med Pay	OTC Deductible	Other Coverage & Deductibles
Loss Payee					Collision Deductible	

INSURED VEHICLE

Veh #	Year	Make	Body Type	Plate Number	State
		Model	V.I.N.		

Owner's Name & Address:	Residence Phone: Business Phone:
Driver's Name & Address:	Residence Phone: Business Phone:

Relation to Insured	Date of Birth	Driver's License No.	State	Used with Permission ☐ Yes ☐ No
Describe Damage:	Estimate Amount	Where can vehicle be seen		When can veh be seen?

PROPERTY DAMAGED

Describe Property (year, make, model, etc.)	Other Veh/Prop Insurance ☐ Yes ☐ No	Company or Agent Name Policy #: Claim #:

Owner's Name & Address	Residence Phone: Business Phone:
Other Driver's Name & Address	Residence Phone: Business Phone:

Describe Damage:	Estimate Amount:	Where can damage be seen

INJURED

Name & Address	Phone No.	Ped	IIV	OV	Age	Extent of Injury

WITNESSES OR PASSENGERS

Name & Address	Phone No.	IV	OV	Other (Specify)
Remarks:				