Commonwealth of Virginia
Department of General Services - Division of Risk Management
AUTOMOBILE LOSS NOTICE

Date Reported	Policy / Plan 1 - 445400	Date and Time of Loss ☐AM ☐PM	DRM Use Only

Name and Address of State Agency	Agency Number Agency Phone and Fax	Adjuster	Claim Number

Location of Accident (street, city, county, state)	Agency Contact

Accident Description	Police Notified ☐Yes ☐No Officer & Badge #	Department Officer Phone

Charges / Violations

STATE INFORMATION

Insured Vehicle (Year, Make, Model) , ,	Vin	Plate Number
Owners Name and Address	☐ Agency Owned ☐ Employee Vehicle	☐ Leased to Agency ☐ Rented Vehicle
	Used with Permission ☐ Yes ☐ No	Seat Belt ☐ Yes ☐ No
Drivers Name and Address	Drivers SSN	Relation to Insured
Insured Vehicle Location (if not drivable)	Damage	Estimate Amount

CLAIMANT INFORMATION

Property Damage (If auto: year, make, model)	Plate Number	Insurance co. and Policy No.

Drivers Name and Address	Residence Phone ( )	Business Phone ( )
Other Drivers Name and Address Type same if same as owner	Residence Phone ( )	Business Phone ( )

Damage	Drivable ☐ Yes ☐No	Estimate Amount	Vehicle Location (if not drivable)

Injured Name, Address, and SSN	Phone Number ( )	Injury	Doctor / Hospital

Witness Name and Address	Phone Number ( )

Remarks

Reported By	Signature	Phone Number ( )