Adventist Risk Management, Inc.

AUTOMOBILE LOSS NOTICE

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: 1 (888) 951-4ARM (4276) | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

▷ INSURED:

CHURCH, SCHOOL OR OTHER: | CONTACT NAME: | CONTACT - HOME PHONE:
CONFERENCE/MISSION: | CONTACT EMAIL: | CONTACT - WORK PHONE:

▷ LOSS INFORMATION:

MONTH	DAY	YEAR	TIME
			AM PM

LOCATION OF ACCIDENT - ADDRESS: | CITY: | STATE: | ZIP CODE:
DATE REPORTED TO POLICE *(MM/DD/YYYY)*: | POLICE REPORT NUMBER: | VIOLATIONS / CITATIONS:
DESCRIPTION OF ACCIDENT/NATURE OF ACTIVITY *(USE ADDITIONAL SHEET IF NECESSARY)*

▷ INSURED VEHICLE:

YEAR, MAKE, MODEL: | V.I.N. (LAST 5 DIGITS OF ID#):
OWNER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:
ADDRESS: | CITY: | STATE: | ZIP CODE:
DRIVER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:
ADDRESS: | CITY: | STATE: | ZIP CODE:
RELATIONSHIP TO INSURED: | DATE OF BIRTH: | PURPOSE OF VEHICLE USE: | WAS DRIVER INJURED? ☐ YES ☐ NO
DESCRIBE DAMAGE: | USED WITH PERMISSION? ☐ YES ☐ NO
ESTIMATE AMOUNT: | WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ DAMAGED PROPERTY: *FOR VEHICLE INFORMATION OTHER THAN ABOVE*

DESCRIBE PROPERTY (IF AUTO: YEAR, MAKE, MODEL, PLATE NO):
INSURANCE COMPANY OR AGENCY NAME & POLICY # (IF ANY):
OWNER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:
ADDRESS: | CITY: | STATE: | ZIP CODE:
DRIVER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:
ADDRESS: | CITY: | STATE: | ZIP CODE:
DESCRIBE DAMAGE: | ESTIMATE AMOUNT:
WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE: | WAS DRIVER INJURED? ☐ YES ☐ NO

▷ PASSENGERS: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ☐ NO
ADDRESS: | CITY: | STATE: | ZIP CODE:
NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ☐ NO
ADDRESS: | CITY: | STATE: | ZIP CODE:
NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ☐ NO
ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ WITNESSES: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER:
ADDRESS: | CITY: | STATE: | ZIP CODE:
NAME: | M.I. | LAST NAME: | PHONE NUMBER:
ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ INCIDENT REPORTED BY: | DATE (MM/DD/YYYY):
▷ LOSS NOTICE COMPLETED BY: | DATE (MM/DD/YYYY):
▷ SIGNATURE OF INSURED'S AUTHORIZED REPRESENTATIVE: | DATE OF SIGNING (MM/DD/YYYY):