Policy#: _____
Expiration Date: _____

AUTOMOBILE LOSS NOTICE

*Required Field

*MEMBER/NAME AND ADDRESS: _____

PHONE: _____

*DATE AND TIME OF LOSS: _____

*LOCATION OF LOSS: _____
(INCLUDE CITY/STATE)

*FACTS OF THE ACCIDENT:_____

AUTHORITY CONTACTED:_____ REPT #: _____

YOUR VEHICLE: YEAR_____ MAKE_____ * VIN#:_____

DRIVER _____ PHONE #: _____

DRIVERS RELATIONSHIP TO INSURED: _____

WAS DRIVER WORKING AT TIME OF LOSS: _____

DESCRIBE DAMAGE TO ASSURED VEHICLE:_____

WHERE CAN VEHICLE BE SEEN: _____

OWNER OF THE OTHER VEHICLE OR PROPERTY:_____
(INCLUDE NAME/ADDRESS/PHONE)

DRIVER OF OTHER VEHICLE: _____

DRIVER OF OTHER VEHICLE INSURANCE COMPANY: _____

WHAT TYPE OF VEHICLE IS IT:_____

DESCRIBE DAMAGE TO OTHER VEHICLE: _____

INJURIES: _____

WITNESSES/PASSENGERS: _____

*REPORTED BY: * PHONE#: *DATE:

_____ _____ _____

SEND COMPLETED FORM TO REPORTACLAIM@CATHOLICMUTUAL.ORG OR FAX TO 402-551-2943.