



AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY PHONE (A/C, No, Ext): 310-265-9600 PROWORKS INSURANCE SERVICES INC LICENSE #0D63158 727 SILVER SPUR ROAD SUITE #200 ROLLING HILLS ESTATES, CA 90274		COMPANY	NAIC CODE:	MISCELLANEOUS INFO (Site & location code)			
FAX (A/C, No): 310-265-9700 E-MAIL ADDRESS:		POLICY NUMBER	POLICY TYPE	REFERENCE NUMBER	CAT #		
CODE:	SUB CODE:	EFFECTIVE DATE	EXPIRATION DATE	DATE OF ACCIDENT AND TIME	AM	PREVIOUSLY REPORTED	
AGENCY CUSTOMER ID:					PM	YES	NO

INSURED		CONTACT		CONTACT INSURED
NAME AND ADDRESS		SOC SEC # OR FEIN:	NAME AND ADDRESS	WHEN TO CONTACT:
				WHERE TO CONTACT
RESIDENCE PHONE (A/C, No):		RESIDENCE PHONE (A/C, No):		
BUSINESS PHONE (A/C, No, Ext):		BUSINESS PHONE (A/C, No, Ext):		
CELL PHONE (A/C, No):		CELL PHONE (A/C, No):		
E-MAIL ADDRESS:		E-MAIL ADDRESS:		

LOSS		AUTHORITY CONTACTED:	VIOLATIONS/CITATIONS
LOCATION OF ACCIDENT (Include city & state)		REPORT #:	
DESCRIPTION OF ACCIDENT (Use separate sheet, if necessary)			

POLICY INFORMATION						
BODILY INJURY (Per Person)	BODILY INJURY (Per Accident)	PROPERTY DAMAGE	SINGLE LIMIT	MEDICAL PAYMENT	OTC DEDUCTIBLE	OTHER COVERAGE & DEDUCTIBLES (UM, no-fault, towing, etc.)
LOSS PAYEE					COLLISION DED	
UMBRELLA/EXCESS	UMBRELLA	EXCESS	CARRIER:	LIMITS:	AGGR	PER CLAIM/OCC
						SIR/DED

INSURED VEHICLE						
VEH #	YEAR	MAKE:	BODY TYPE:	PLATE NUMBER	STATE	
		MODEL:	V.I.N.:			
OWNER'S NAME & ADDRESS				RESIDENCE PHONE (A/C, No):		
				BUSINESS PHONE (A/C, No, Ext):		
DRIVER'S NAME & ADDRESS				RESIDENCE PHONE (A/C, No):		
				BUSINESS PHONE (A/C, No, Ext):		
<input type="checkbox"/> (Check if same as owner)		RELATION TO INSURED (Employee, family, etc.)	DATE OF BIRTH	DRIVER'S LICENSE NUMBER	STATE	PURPOSE OF USE
						USED WITH PERMISSION? YES NO
DESCRIBE DAMAGE						
ESTIMATE AMOUNT	WHERE CAN VEHICLE BE SEEN?	WHEN CAN VEH BE SEEN?	OTHER INSURANCE ON VEHICLE			

PROPERTY DAMAGED **VEHICLE?** **YES** **NO** **YR:** **MAKE:** **MODEL:** **PLATE #:**

DESCRIBE PROPERTY (Other Than Vehicle)	OTHER VEH/PROP INS? <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY OR AGENCY NAME: POLICY #:
OWNER'S NAME & ADDRESS		RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):
OTHER DRIVER'S NAME & ADDRESS <input type="checkbox"/> (Check if same as owner)		RESIDENCE PHONE (A/C, No): BUSINESS PHONE (A/C, No, Ext):
DESCRIBE DAMAGE		
ESTIMATE AMOUNT	WHERE CAN DAMAGE BE SEEN?	

INJURED

NAME & ADDRESS	PHONE (A/C, No)	PED	INS VEH	OTH VEH	AGE	EXTENT OF INJURY
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (A/C, No)	INS VEH	OTH VEH	OTHER (Specify)
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

REPORTED BY	REPORTED TO
SIGNATURE OF INSURED DATE (MM/DD/YYYY)	SIGNATURE OF PRODUCER DATE (MM/DD/YYYY)

REMARKS (Include Adjuster Assigned)