

EFFECTIVE AT 12:01 A.M. ON 12-31-2000

IN CASE OF ACCIDENT CALL

CRAWFORD & COMPANY AT

1-866-219-6120

INFORMATION EXCHANGE

Use this card to obtain key information from the other driver involved.

NAME		TELEPHONE NO.	
ADDRESS:	STREET	CITY	STATE ZIP CODE
NAME OF YOUR INSURANCE COMPANY			
YEAR AND MAKE OF VEHICLE	ARE YOU THE OWNER?	LICENSE NUMBER	
INJURED PASSENGERS		ADDRESSES:	
WITNESSES		ADDRESSES:	

BG-0067 04-83

Use Reverse Side If Necessary

TO A PASSING MOTORIST

YOUR ASSISTANCE WILL BE APPRECIATED IN CARRYING OUT THE INSTRUCTIONS BELOW:

CALL NEAREST POLICE DEPARTMENT

CALL AN AMBULANCE

CALL A WRECKER

CONTACT, _____

AT: _____

LOCATION OF VEHICLE _____

TYPE OF ASSISTANCE NEEDED _____

DRIVER'S NAME _____

In case of an accident or breakdown when you should not leave your vehicle, fill out this card and hand it to a passing motorist.

BA0102 09-94

REMARKS:		
DATE	TIME	DID YOU SEE ACCIDENT HAPPEN
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
YOUR NAME	TELEPHONE NUMBER	

PLEASE PRINT

Witness Courtesy Card

Witness Courtesy Card

PLEASE PRINT

YOUR NAME		TELEPHONE NUMBER
ADDRESS (STREET, CITY, STATE, ZIP CODE)		
DATE	TIME	DID YOU SEE ACCIDENT HAPPEN
REMARKS:		

AUTOMOBILE LOSS NOTICE

DATE REPORTED	POLICY/PLAN	DATE AND TIME OF LOSS ___ AM ___ PM	DRM USE ONLY	
NAME AND ADDRESS OF STATE AGENCY		AGENCY NUMBER	ADJUSTER	CLAIM NUMBER
		AGENCY PHONE AND FAX () ()		AGENCY CONTACT
LOCATION OF ACCIDENT (STREET, CITY, COUNTY, STATE)			POLICE NOTIFIED ___ YES ___ NO	DEPARTMENT
ACCIDENT DESCRIPTION			OFFICER	OFFICER PHONE ()
			CHARGES / VIOLATIONS	

STATE INFORMATION

INSURED VEHICLE (YEAR, MAKE, MODEL)	VIN	PLATE NUMBER
OWNERS NAME AND ADDRESS	___ AGENCY OWNED	___ LEASED TO AGENCY
	___ EMPLOYEE VEH	___ RENTED VEH
DRIVERS NAME AND ADDRESS	USED WITH PERMISSION ___ YES ___ NO	SEAT BELT ___ YES ___ NO
	DRIVERS SSN	RELATION TO INSURED
INSURED VEH 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 ()	
OWNER'S NAME AND ADDRESS	RESIDENCE PHONE ()		BUSINESS PHONE ()	
DAMAGE	DRIVABLE ___ YES ___ NO	ESTIMATE AMOUNT	VEH LOCATION (IF NON DRIVABLE)	
INJURED NAME, ADDRESS AND SSN	PHONE ()	INJURY	DOCTOR / HOSPITAL	
WITNESSES NAME AND ADDRESS			PHONE ()	
REMARKS				
REPORTED BY	SIGNATURE			PHONE ()

IF YOU HAVE AN ACCIDENT

STOP IMMEDIATELY

Take all necessary precautions to prevent further accidents at the scene.

SEND FOR HELP - DO NOT LEAVE

Ask a passing motorist or some other person to contact the State Police, or call 911.

GET NAMES OF WITNESSES

Fill out the enclosed accident report form and notify your Supervisor.

DO NOT

Make a statement of any kind to anyone other than your employer, an enforcement officer or a representative of Crawford and Company or Hilb, Rogal and Hamilton.

IMPORTANT

**IF ANYONE IS INJURED
OR
THE VEHICLES ARE DISABLED**

**PHONE
1-866-219-6120**

**or FAX
1-804-673-9425**

IN CASE OF MOTOR VEHICLE ACCIDENT:

- (1) REPORT THE ACCIDENT TO THE STATE POLICE;
- (2) REPORT THE ACCIDENT TO CRAWFORD & CO.
CLAIMS #1-866-219-6120

NOTE: THIS COVERS BOTH LIABILITY AND PHYSICAL DAMAGE TO RENTAL VEHICLES. DO NOT PURCHASE THE COLLISION DAMAGE WAIVER FOR VEHICLES USED ON STATE BUSINESS.

CONTRACT # C-900093



**COMMONWEALTH OF VIRGINIA
LIABILITY PLAN**

THE COMMONWEALTH OF VIRGINIA, ITS AGENCIES, INSTITUTIONS, OFFICERS, AGENTS, AND EMPLOYEES ARE COVERED FOR THEIR OFFICIAL DUTIES AND AUTHORITY BY A LIABILITY AND AUTOMATIC PHYSICAL DAMAGE PLAN ADMINISTERED BY THE DEPARTMENT OF THE TREASURY, DIVISION OF RISK MANAGEMENT PURSUANT TO SECTIONS 2.1-191.11 AND 2.1-191.12 OF THE CODE OF VIRGINIA.

Department of the Treasury
Division of Risk Management
P.O. Box 1879, Richmond, VA 23218-1879
(804) 786-3152

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