DO NOT ALTER THE FORMAT OF THIS DOCUMENT

AUTO LIABILITY UNIFORM COVER LETTER

TO: **RISK MANAGEMENT/AUTO LIABILITY,** 801 S. 7th St., 6th Fl. Annex, Springfield, IL 62703

FROM: NAME: **AGENCY:** **PHONE:**

DATE:

RE: INITIAL REPORT OF VEHICLE ACCIDENT *** DENOTES CMS USE ONLY**

CLAIM CANNOT BE CONSIDERED AS RECEIVED WITHOUT THIS REQUIRED INFORMATION

AGENCY/DIV CODE (FIVE DIGIT #)**: _____**
STATE DRIVER'S SOCIAL SECURITY #:_____ DEPT FILE NO: _____
STATE DRIVER'S NAME: _____ WORK PHONE: _____
STATE DRIVER'S HOME ADDRESS:_____ HOME PHONE: _____
STATE DRIVER'S CITY: _____ STATE: _____ ZIP: _____
ACCIDENT DATE: _____ *DATE RECEIVED BY CMS_____

WAS STATE DRIVER IN THE COURSE OF EMPLOYMENT: yes no
LICENSE # ON VEHICLE_____
DOES CLAIM INVOLVE: Property damage: y / n Bodily injury: y / n Wrongful death: y / n DUI: y / n
ACCIDENT STATE: _____ CITY:_____
STREET 1: _____ STREET 2: _____
WAS STATE DRIVER TICKETED: **yes no (**if yes - describe)_____
IS VEHICLE OWNED BY: STATE /EMPLOYEE /RENTAL CO /OTHER: (circle one)
DESCRIBE WHAT HAPPENED:
_____
_____
_____

OTHER OWNER/DRIVER INFORMATION

DRIVER'S NAME _____ HOME PHONE: _____
STREET: _____ WORK PHONE:_____
CITY: _____ STATE: _____ ZIP: _____

OWNER (IF OTHER THAN DRIVER): HOME PHONE:_____
STREET: _____ WORK PHONE: _____
CITY: _____ STATE: _____ ZIP: _____

AUTO: YR: _____ MAKE: _____ MODEL: _____
VIN: (if known)_____ **LIC: _____**

PASSENGER INFORMATION

PASSENGER NAME: _____ HOME PHONE : _____WORK PHONE:_____
PASSENGER STREET: _____
PASSENGER CITY: _____
WAS PASSENGER IN: STATE VEH OTHER VEH (CIRCLE CHOICE)

STATE VEHICLE DAMAGE: _____ EXPECTED RECOVERY_____

COVER LETTER WITH SR -1 MUST BE REPORTED TO CMS WITHIN 7 CALENDAR DAYS AFTER ACCIDENT