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 <u>MUST</u> BE REPORTED TO CMS WITHIN 7 CALENDAR DAYS AFTER ACCIDENT