

**SPECIALTY CLAIMS SERVICES INC., P.O. BOX 381136, CLINTON TWP., MI 48038 (877) 855-8614**

In order to assist us in evaluating your claim, please complete the "General" information section and any following sections which apply. Please be as descriptive as possible. Sign at the bottom and mail to the above address. (Completion of this form does not imply that your claim will be paid or that the Road Commission is liable for your damages.)

<b>G E N E R A L</b>	<p><b>NAME:</b> _____</p> <p><b>ADDRESS:</b> _____ <b>CITY:</b> _____</p> <p><b>STATE:</b> _____ <b>ZIP CODE:</b> _____ <b>PHONE: (HOME):</b> _____ <b>(WORK):</b> _____</p> <p><b>COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED:</b> _____</p> <p><b>IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER:</b> _____</p> <p><b>DATE &amp; TIME OF ACCIDENT/INCIDENT:</b> _____</p> <p><b>LOCATION OF ACCIDENT/INCIDENT:</b> _____</p> <p><b>POLICE NOTIFICATION? YES</b> _____ <b>NO</b> _____ <b>COMPLAINT NUMBER:</b> _____</p> <p><b>DESCRIPTION OF ACCIDENT/INCIDENT:</b> _____</p> <p>_____</p> <p><b>WITNESSES: YES</b> _____ <b>NO</b> _____ (If so, provide name, address, and telephone numbers on back of this form.)</p>
<b>I N J U R Y</b>	<p><b>INJURED? YES</b> _____ <b>NO</b> _____ (If yes, please describe): _____</p> <p>_____</p> <p><b>MEDICAL FACILITY TREATED AT:</b> _____</p> <p><b>ARE YOU TREATING NOW? YES</b> _____ <b>NO</b> _____</p> <p><b>HAVE YOU LOST ANY TIME FROM WORK?: YES</b> _____ <b>NO</b> _____ (If yes, how long?): _____</p> <p><b>NAME, ADDRESS, PHONE NUMBER OF EMPLOYER:</b> _____</p> <p>_____</p> <p><b>DATE RETURNING TO WORK:</b> _____</p>
<b>A U T O</b>	<p><b>AUTOMOBILE INVOLVED: MAKE:</b> _____ <b>MODEL:</b> _____ <b>YEAR:</b> _____</p> <p><b>DESCRIBE DAMAGE:</b> _____</p> <p>_____</p> <p><b>ATTACH (2) ESTIMATES: SHOP #1 EST. \$</b> _____ <b>SHOP #2 EST. \$</b> _____</p> <p><b>AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier):</b> _____</p> <p>_____</p> <p><b>AGENT'S NAME:</b> _____ <b>POLICY #:</b> _____</p> <p><b>COLLISION COVERAGE: YES:</b> _____ <b>NO:</b> _____ <b>DEDUCTIBLE \$</b> _____</p> <p><b>COMPREHENSIVE COVERAGE: YES:</b> _____ <b>NO:</b> _____ <b>DEDUCTIBLE \$</b> _____</p> <p><b>HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES:</b> _____ <b>NO:</b> _____</p>
<b>P R O P E R T Y</b>	<p><b>DESCRIBE PROPERTY DAMAGE:</b> _____</p> <p>_____</p> <p><b>ATTACH (2) ESTIMATES: EST. #1 \$</b> _____ <b>EST. #2 \$</b> _____</p> <p><b>PROPERTY COVERAGE: YES</b> _____ <b>NO</b> _____ <b>DEDUCTIBLE \$</b> _____</p> <p><b>NAME, ADDRESS, PHONE NUMBER &amp; AGENT'S NAME:</b> _____</p> <p>_____ <b>POLICY #:</b> _____</p>

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(Required)

**NOTE:** A police report and a copy of your insurance declaration page (showing policy dates and coverage's, pertinent to accident date) will be required to give full attention to your claim. Any information requested on this form that you fail to supply will only cause delay in the processing of your claim. Please allow 3 to 4 weeks for handling of this claim.