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

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