

CLAIM PLACEMENT FORM

<input type="checkbox"/> SUSPEND DRIVERS LICENSE	Adjuster Name: _____	Client Code: _____
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(UNINSURED Assignment)
 (INSTALLMENT Assignment)
 (ARBITRATION Assignment)
 (LEGAL Assignment)
 (RETAIL Assignment)



5105 E Los Angeles Ave, Suite 200"
 Simi Valley, Ca 93063
 Office Number: 1-805-522-6774
 Fax: (805) 522-6704

Insured Name: _____	Claim Number: _____
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Claim Breakdown

Property Damage	\$
Deductible (Waived: <input type="checkbox"/>)	\$
Uninsured Motorist (UMBI)	\$
Medical Payments	\$
Other	\$
Total Claim Amount	\$

Claim Type (check all that apply)

<input type="checkbox"/> Material Damage (Collision)	<input type="checkbox"/> Uninsured Motorist Property Damage
<input type="checkbox"/> Uninsured Motorist Bodily Injury	<input type="checkbox"/> Med-Pay Reimbursement
<input type="checkbox"/> Unjust Enrichment	<input type="checkbox"/> Property Claim
<input type="checkbox"/> Commercial Line Claim	
<input type="checkbox"/> Other:	

Statute of Limitations: _____

Date of Loss: _____

Documents Available (check all that apply)

<input type="checkbox"/> Police Report	<input type="checkbox"/> Fire Incident Report
<input type="checkbox"/> Cause & Origin Report	<input type="checkbox"/> Repair Estimate(s)
<input type="checkbox"/> Claim Payment Draft(s)	<input type="checkbox"/> Photos
<input type="checkbox"/> Witness Statement(s)	<input type="checkbox"/> Insured Statement
<input type="checkbox"/> Other:	

Loss Location: _____

Claimant Vehicle: Year: Make: Model: Lic. Plate #:

Facts of Loss:

Claimant 1 (DRIVER)

Claimant 2 (REGISTERED OWNER)

Name: Soc. Sec. #: Drivers Lic. #: Street Address: City, State, Zip: Employer: Home Phone: Work Phone:	Name: Soc. Sec. #: Drivers Lic. #: Street Address: City, State, Zip: Employer: Home Phone: Work Phone:
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