

THIS FORM SHOULD ONLY BE PROVIDED
TO THE OFFICE OF RISK MANAGEMENT

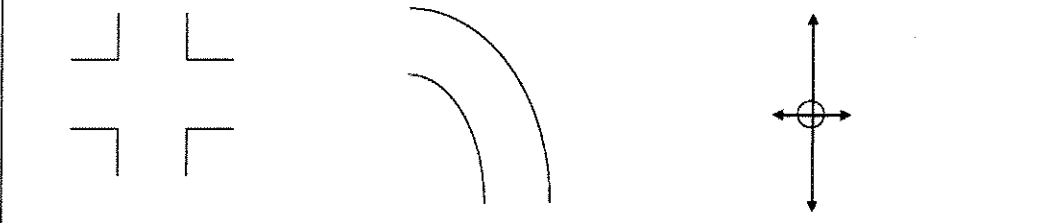
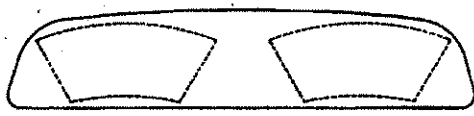
GEORGE MASON UNIVERSITY
Automobile Loss Notice Form

CALL THE POLICE

When an accident occurs, follow the instruction on the envelope provided in your glove compartment.
Any questions should be referred to Mason's Office of Risk Management at 703-993-2599.

DO NOT DISCUSS ACCIDENT WITH ANYONE EXCEPT RISK MANAGEMENT, DRM, OR THE POLICE.

POLICY-HOLDER	NAME GEORGE MASON UNIVERSITY - OFFICE OF RISK MANAGEMENT						PHONE 703-993-2599	
	ADDRESS: STREET 4400 UNIVERSITY DRIVE, MSN 6D6		CITY FAIRFAX	STATE VA	ZIP CODE 22030	FAX 703-993-2339		
TIME AND PLACE OF ACCIDENT	DATE OF ACCIDENT	HOUR <input type="checkbox"/> AM <input type="checkbox"/> PM	LOCATION STREET OR HIGHWAY	CITY	COUNTY	STATE		
	MAKE OF AUTO		YEAR	BODY TYPE	VEHICLE IDENTIFICATION NUMBER (VIN #)	STATE VEHICLE LICENSE PLATE #		
STATE AGENCY OR COMMUNITY SERVICES BOARD as Insureds USE ONLY	NAME OR OWNER OR LEASING COMPANY			ADDRESS: STREET	CITY	STATE	ZIP CODE	
	NAME OF DRIVER			ADDRESS: STREET	CITY	STATE	ZIP CODE	
	DRIVER'S DATE OF BIRTH	DRIVER'S LICENSE NUMBER		DRIVER CONTACT #:	WAS LICENSE IN EFFECT AT THE TIME OF ACCIDENT?			
	WAS AUTO BEING OPERATED FOR BUSINESS OR PLEASURE <input type="checkbox"/> BUSINESS <input type="checkbox"/> PLEASURE		WHO GAVE PERMISSION?		WHERE WAS THE DRIVER GOING TO AND COMING FROM AT TIME OF ACCIDENT?			
	DESCRIBE PARTS DAMAGED AND EXTENT OF DAMAGE (NOTE: BY TERMS OF YOUR POLICY THE COMPANY MUST BE GIVEN REASONABLE OPPORTUNITY TO EXAMINE AUTO BEFORE REPAIRS ARE MADE) (IF GLASS DAMAGE, SEE SECOND PAGE)							
	WHERE MAY AUTO BE SEEN?		ESTIMATED COST OF REPAIRS		WHERE IS THE VEHICLE NORMALLY GARAGED? (CITY & STATE)			
	MAKE OF AUTO		YEAR	LICENSE NUMBER	ESTIMATED COST OF REPAIRS			
OTHER AUTO INVOLVED	PARTS DAMAGED AND EXTENT OF DAMAGE							
	NAME OF OWNER			ADDRESS: STREET	CITY	STATE	ZIP CODE	PHONE NUMBER
	NAME OF DRIVER			ADDRESS: STREET	CITY	STATE	ZIP CODE	PHONE NUMBER
	IS AUTO INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF INSURANCE COMPANY					
	NAMES OF PASSENGERS IN YOUR AUTO			ADDRESSES: STREET	CITY	STATE	ZIP CODE	
PASSENGERS	NAMES OF PASSENGERS IN OTHER AUTO			ADDRESSES: STREET	CITY	STATE	ZIP CODE	
	NAMES OF PERSON INJURED			ADDRESSES:	INJURIES	AGE		
	IN WHICH AUTO WERE INJURED RIDING?							
INJURIES (No Matter How Minor)	NAME OF DOCTOR OR HOSPITAL			ADDRESS: STREET	CITY	STATE	ZIP CODE	

PROPERTY DAMAGES OTHER THAN AUTO	NAME OR OWNER	ADDRESS: STREET CITY STATE ZIP CODE				
	KIND OF PROPERTY					
	ESTIMATED COST OF REPAIR	WHERE MAY PROPERTY BE SEEN?				
WITNESSES	NAMES:	ADDRESSES: STREET CITY STATE ZIP CODE				
DESCRIPTION OF ACCIDENT	ON WHAT STREET OR ROAD WERE YOU DRIVING?	DIRECTION	SPEED	STREET OR ROAD OTHER AUTO WAS DRIVING ON?	DIRECTION	SPEED
	WHERE YOUR LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM	WERE THE OTHER AUTO'S LIGHTS ON? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> BRIGHT <input type="checkbox"/> DIM	WHAT TRAFFIC CONTROLS?		FOR WHOM?	SPEED LIMIT
	DID EITHER DRIVER GIVE SIGNAL OR ANY KIND? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHO?	IF INTERSECTION, WHO ENTERED FIRST?			WHO HAD RIGHT OF WAY?	
	WHICH DRIVER VIOLATED TRAFFIC ORDINANCE?	CHARGE:	DID POLICE INVESTIGATE ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICE ADDRESS		
	DESCRIBE, IN YOUR OWN WORDS, HOW ACCIDENT HAPPENED:					
	SHOW ON THE DIAGRAM THE POSITION OF ALL AUTOS, PERSONS, STOP LIGHTS, STOP SIGNS AND OTHER OBJECTS, SHOW STREET NAMES					
<div style="display: flex; align-items: center;">  <div style="margin-left: 20px;"> <p><input type="checkbox"/> 1 MY AUTO</p> <p><input type="checkbox"/> 2 OTHER AUTO</p> <p><input type="checkbox"/> 3 THIRD AUTO</p> <p><input type="checkbox"/> PEDESTRIAN</p> <p><input type="checkbox"/> STOP SIGN</p> <p><input type="checkbox"/> YIELD SIGN</p> <p><input type="checkbox"/> STOP LIGHT</p> </div> </div>						
GLASS BREAKAGE	NOTE: By terms of your policy, the company must be given reasonable opportunity to examine auto before repairs are made					
	LOCATION OF BREAKAGE <input type="checkbox"/> DOOR <input type="checkbox"/> VENT <input type="checkbox"/> REAR <input type="checkbox"/> WINDSHIELD <input type="checkbox"/> OTHER, DESCRIBE					
	TYPE OF GLASS <input type="checkbox"/> TINTED <input type="checkbox"/> SAFETY <input type="checkbox"/> CLEAR <input type="checkbox"/> PLATE		TYPE OF BREAK <input type="checkbox"/> SHATTERED <input type="checkbox"/> CRACKED <input type="checkbox"/> CHIPPED OR PITTED <input type="checkbox"/> BULL'S EYE (O) <input type="checkbox"/> HALF MOON (J)			
	WINDSHIELD DAMAGE: CHECK ITEMS ABOVE AND MARK LOCATION OF DIAGRAM:					
						
DO YOU THINK A CLAIM WILL BE MADE AGAINST YOU? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN			BY WHOM?			
DATE OF REPORT			SIGNATURE			