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# Automobile Claim Form

# League of Minnesota Cities Insurance Trust (LMCIT)

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| --- | --- | --- | --- |
| Send To | LMCIT Claims145 University Ave WSt. Paul MN 55103-2044 | PhoneFax | (651) 281-1287(800) 925-1122(651) 281-1297 |
|  |  | Email | claims@lmc.org |

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| --- |
| Contact Information |

|  |  |
| --- | --- |
| Today’s Date |  |
| Member (City / Entity) Name |  |
| Member (City / Entity) Address (Street, City, State, Zip) |  |
| Contact Person |  |
| Contact Person Phone Number |  |

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| --- |
| Covenant Information |

|  |  |
| --- | --- |
| Covenant Number (if known) |  |
| Covenant Period (if known) |  |

|  |
| --- |
| Accident Information |

|  |  |
| --- | --- |
| Date of Accident |  |
| Time of Accident (am/pm) |  |
| Reported Previously? |  |
| Description of Accident |  |

|  |
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| Insured Vehicle Information |

|  |  |
| --- | --- |
| Year |  |
| Make |  |
| Model |  |
| VIN |  |
| Driver’s Name & Job Title |  |
| Phone Number |  |
| Estimated Damage Amount |  |
| Description of Damage |  |

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| --- |
| Other Vehicle / Property Damage Information |

|  |  |
| --- | --- |
| Year |  |
| Make |  |
| Model |  |
| VIN |  |
| Owner’s Name & Address (Street, City, State, Zip) |  |
| Phone Number |  |
| Driver’s Name (if different from owner) |  |
| Phone Number (if different from owner) |  |
| Any Insurance? (If yes, provide company, agent name, & phone.) |  |
| Estimated Damage Amount |  |
| Description of Damage |  |

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| --- |
| Bodily Injury Information |

|  |  |
| --- | --- |
| Injured Person’s Name & Address (Street, City, State, Zip) |  |
| Phone Number |  |
| Description of Injury |  |

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| --- |
| Additional Information / Comments |

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|  |
| --- |
| Signature |

|  |  |
| --- | --- |
| Reported By |  |
| Signature |  |
| Date |  |