**Please send completed form as soon as practicable to:**

|  |  |
| --- | --- |
| **Claims Associates, Inc.**  **PO. Box 1898**  **Sioux Falls, SD 57101** | **Fax No: 605-333-9835** |
|  | **Office Phone: 605-333-9810** |
|  | **After hours 888-430-2249** |
|  | **Email:** [**asbsdclaims@claimsassoc.com**](mailto:asbsdclaims@claimsassoc.com) |

|  |  |  |
| --- | --- | --- |
| Report Date: | Date of Loss and Time: | Previously Reported (Y/N): |

**MEMBER INFORMATION**

|  |  |
| --- | --- |
| School District Name and Street Address: |  |
| Person at School District to Contact About this Loss (name, phone, and email): |  |

**LOSS INFORMATION**

|  |  |
| --- | --- |
| Location of Loss Street Address: |  |
| Describe Location of Loss if Not at a Specific Street Address: |  |
| Police or Fire Department Contacted and Report Number: |  |
| Description of Accident: | |

**COVERED VEHICLE INFORMATION**

|  |  |
| --- | --- |
| Year, Make, Model, VIN, and Plate Number: |  |
| Name, Address, Phone, and Email of Vehicle Owner (if not same as member): |  |

**DRIVER INFORMATION**

|  |  |
| --- | --- |
| Name, Address, Phone Number, and Email of Driver: |  |
| Driver’s License Number and State: |  |
| Describe Damage to Covered Vehicle: |  |
| Any Other Insurance Covering This Vehicle (ins co name and policy number): |  |

**OTHER VEHICLE / PROPERTY DAMAGED**

|  |  |
| --- | --- |
| Year, Make, Model, VIN, and Plate # of Other Vehicle: |  |
| Name, Address, Phone Number, and Email of Other Vehicle Owner: |  |
| Driver’s License Number and State: |  |
| Describe Damage to Other Vehicle: |  |
| Any Other Insurance Covering This Vehicle (ins co name and policy number)? |  |
| Name, Address, Phone, and Email of Other Property Owner (o/t vehicles): |  |
| Describe Damage to Property (other than vehicles): |  |
| Any Other Insurance Covering Property (ins co name and policy number)? |  |

**INJURED**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name and Address | Phone No. | Ped | Cov Veh | Oth Veh | Age | Extent of Injury |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**WITNESSES OR PASSENGERS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name and Address | Phone No. | Ped | Cov Veh | Oth Veh | Age | Extent of Injury |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Report By: | Signature: |

**ADDITIONAL COMMENTS THAT MAY BE OF ASSISTANCE IN HANDLING THIS CLAIM:**

|  |
| --- |
|  |
| **IMPORTANT ADDITIONAL INSTRUCTIONS:** Please send copies of any legal papers, correspondence, or any other documentation related to this matter. |
| **APPLICABLE IN SOUTH DAKOTA:** Any person who knowingly and with intent to defraud any insurance company or another person, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties. |