**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 number, and email): |  |

**CLAIMANT INFORMATION**

|  |  |
| --- | --- |
| Claimant Name, Street Address, Phone Number, and Email: |  |
| Name, Street Address, Phone Number, and Email of Claimant’s Attorney: |  |

**LOSS INFORMATION**

|  |  |
| --- | --- |
| Did you receive legal papers? |  |
| If so, when? |  |
| Have you reported this claim/circumstance to any other insurance company? |  |
| If yes, please identify insurance company, policy #, and type of coverage provided: |  |
| Briefly describe nature of claim/circumstance: |  |
| Describe nature of and amount of loss or damage by the claimant: |  |

|  |  |  |
| --- | --- | --- |
| Report By: | Signature: | Date Signed: |

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

|  |
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|  |
| **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. |