To report a claim, please fax: 866-668-7780 or email:  MCCLoss@mvsc.com

*Note: Any question with an asterisk (\*) is required information.*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Information | | | | | | | | | | | | | | | | |
| \*GB Client Number | | | | 000020 | | | | | | | | | | | | |
| \*Client Name | | | | MCC/Province of Detroit | | | | | | | | | | | | |
| Date and Time | | | | | | | | | | | | | | | | |
| \*Incident Date | | | | Enter date. | | | | | Incident Time | | | | | Enter Time. | | |
| \*Insured Notified Date | | | | Enter date. | | | | | | | | | | | | |
| Client Location | | | | | | | | | | | | | | | | |
| \*Location Code | | | | Enter Location Code. | | | | | | | | | | | | |
| \*Name | | | | Enter Name. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | | | \*State | | Choose State. | | | | | ZIP | Enter ZIP. | | |
| Phone Number | Enter phone #. | | | | | | | | | | |  | | | | |
| Submitter Information | | | | | | | | | | | | | | | | |
| Name | | | | Enter Name. | | | | | | | | | | | | |
| Title | | | | Enter Title. | | | | | | | | | | | | |
| Email Address | | | | Enter Email. | | | | | | | | | | | | |
| Phone Number | | | | Enter Phone #. | | | | | | | | | | | | |
| Incident Information | | | | | | | | | | | | | | | | |
| \*Detailed Description of Incident, including any injuries (limit the characters to 250) | | | | Enter Description. | | | | | | | | | | | | |
| Witnesses *(Only if any Witnesses)* | | | | | | | | | | | | |  | | | |
| First Name | | | | Enter First Name. | | | | | | Last Name | | | | Enter Last Name. | | |
| Home Phone | | | | Enter Phone #. | | | | | | Work Phone | | | | Enter Phone #. | | |
| Location of Incident *(type SAME, if same as reporting location)* | | | | | | | | | | | | | | | | |
| Location Name | | | | Enter Location Name. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | \*State | | | Choose State. | | | | ZIP | | | Enter ZIP. | | |
| Authority | | | | |
| Authority Name | | | | Enter Name. | | | | | | | | | | | | |
| Phone Number | | | | Enter Phone #. | | | | | | | | | | | | |
| Report Number | | | | Enter Report #. | | | | | | | | | | | | |
| Involved Parties *(can add as many as necessary)* | | | | | | | | | | | | | | | | |
| SSN | | | | Enter SSN. | | | | | | | | | | | | |
| \*First Name | | | | Enter Name. | | | | | Middle Initial | | | | | | | Enter Initial. |
| \*Last Name | | | | Enter Name. | | | | |  | | | | | | | |
| Home Phone | | | | Enter Phone #. | | | | | Work Phone/Ext. | | | | | | | Enter Phone #/Ext. |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| Birth Date | Enter date. | | | Date of Death (if applicable) | | | | | Enter date. | | | | | | | |
| Marital Status | Choose... | | | Gender | | | Choose... | | | | | | | | | |
| Drivers License Number | | | | Enter #. | | | | | | | | | | | | |
| State | | | | Choose State. | | | | | | | | | | | | |
| Citation Type | | | | Enter text. | | | | | | | | | | | | |
| \*Relationship to Client (employee, spouse, self, customer, unknown, other) | | | | Enter text. | | | | | | | | | | | | |
| Injured Party | | | |  | | | | | | | | | | | | |
| Injured Party Involvement (Insured vehicle driver, Insured vehicle passenger, other vehicle driver, other vehicle passenger, pedestrian) | | | | Enter text. | | | | | | | | | | | | |
| First Name | | | | Enter Name. | | | | | Middle Initial | | | | | | | Enter Initial. |
| Last Name | | | | Enter Name. | | | | | Age | | | | | | | Enter Age. |
| Extent of Injury | | | | Enter text. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| Phone | Enter Phone #. | | | | | | | | | | | | | | | |
| Medical Provider *(Only if medical treatment rendered for an Injured Party)* | | | | | | | | | | | | | | | | |
| Hospital/Clinic Name | | | | Enter text. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| Phone Number | | | Enter Phone #. | | | | | | | | | | | | | |
| Doctor Name | | | Enter Name. | | | | | | | | | | | | | |
| Street Address | | | Enter Street Address. | | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| Phone Number | | | Enter Phone #. | | | | | | | | | | | | | |
| Vehicle *(can be as many as necessary)* | | | | | | | | | | | | | | | | |
| Third Party Vehicle? | | | Choose... | | | | | Veh/Asset/Fleet Number | | | | | | | Enter #. | |
| VIN | | | Enter #. | | | | | Vehicle Type | | | | | | | Enter text. | |
| Body Type | | | Enter text. | | | | | Year | | | | | | | Enter text. | |
| Make | | | Enter text. | | | | | Model | | | | | | | Enter text. | |
| Color | | | Enter text. | | | | | Plate # | | | | | | | Enter text. | |
| Plate State | | | Choose State. | | | | |  | | | | | | |  | |
| Damage Description | | | Enter text. | | | | | | | | | | | | | |
| Estimated Damage | | | Enter text. | | | | | | | | | | | | | |
| Insurance Company | | | Enter text. | | | | | | | | | | | | | |
| Policy Number | | | Enter text. | | | | | | | | | | | | | |
| When/Where Can Be Seen *(current location of vehicle)* | | | | | | | | | | | | | | | | |
| Name | | | | Enter Name. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| County | Enter text. | | | | | | | | When | | | | | | | Enter text. |
| Owner | Enter text. | | | | | | | | | | | | | | | |
| Property *(if applicable)* | | | | | | | | | | | | | | | | |
| Third Party Property? | | | Choose... | | | | | | | | | | | | | |
| Describe Item(s) | | | Enter text. | | | | | | | | | | | | | |
| Damage Description | | | Enter text. | | | | | | | | | | | | | |
| Estimated Damage | | | Enter text. | | | | | | | | | | | | | |
| Insurance Co. Name | | | Enter text. | | | | | | | | | | | | | |
| Policy Number | | | Enter text. | | | | | | | | | | | | | |
| When/Where Can Be Seen *(current location of vehicle)* | | | | | | | | | | | | | | | | |
| Name | | | | Enter Name. | | | | | | | | | | | | |
| Street Address | | | | Enter Street Address. | | | | | | | | | | | | |
| City | Enter City. | | | State | | | Choose State. | | ZIP | | | | | | | Enter ZIP. |
| When | Enter text. | | | | | | | | | | | | | | | |
| Owner | | Enter Owner Name. | | | | | | | | | | | | | | |
| Contact Information | | | | | | | | | | | | | | | | |
| \*First and Last Name | | Enter First and Last Name. | | | | | | | | | | | | | | |
| \*Phone | | Enter Phone #. | | | | | | | | | | | | | | |
| Notes/Additional Comments *(ie, if this is for report only)* | | | | | | | | | | | | | | | | |
| Additional Remarks | | Enter text. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| NOTE: If employee was injured, please advise if a Work Comp claim should be entered as well. | | | | | | | | | | | | Choose... | | | | |
|  | | | | | | | | | | | | | | | | |