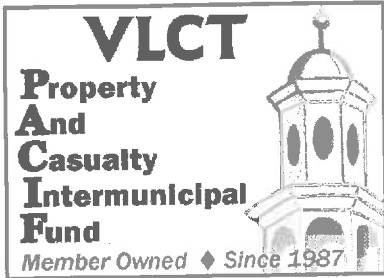

VLCT PACIF
Auto
Loss Notice

Start by saving this blank file on your computer. Open the saved version, fill it in electronically*, save it again, and attach it to an email to newclaim@vlct.org.
***Tips:** Instead of mousing around, use the Tab key to move forward field by field, use Shift-Tab to move backward, and press the Space bar to check a selected check box.

Member name & address	Contact info for employee involved in accident	
Date of accident (mm/dd/yyyy)	Phone number	Email
Time of accident	Location of accident	

Please check one or more of the following to show who responded to the accident scene

Police ☐	Fire ☐	Ambulance ☐	None ☐
Department or jurisdiction that responded			
Incident Number	Citation(s) issued and to whom		

PACIF MEMBER's vehicle, driver, and business use information

Vehicle year	Make	Model	Serial number or VIN	Plate number	State
Driver name & address		Phone numbers H C W	License number	DOB (mm/dd/yyyy)	State
Was the vehicle used with permission? Yes ◯ No ◯		Was the vehicle used for business? Yes ◯ No ◯	Was the driver employed by Member? Yes ◯ No ◯		
Where can member vehicle be seen for inspection?		Specify damage (area, extent, etc.)		Est. damage ($)	

OTHER vehicle, owner, driver, and insurance information

Owner name & address	H C W	License number	State
Is the vehicle owner also the driver? (If yes, please skip to Vehicle year) Yes ◯ No ◯			
Driver name & address	H C W	License number	State

Vehicle year	Make	Model	Serial number or VIN	Plate number	State

Where can other vehicle be seen for inspection?	Specify damage (area, extent, etc.)	Est. damage ($)

Insurance company		Policy number	

Injury information: ***Federal law requires us to obtain the Date of Birth and Social Security number of a party who is injured or collecting Medicare/Medicaid or SSDI.***

Injured 1 name & address	Phone number(s)	DOB (mm/dd/yyyy)	Social Security number
Location during accident Member vehicle ◯ Other vehicle ◯ Pedestrian ◯	Describe injury (-ies)		

Injured 2 name & address	Phone number(s)	DOB (mm/dd/yyyy)	Social Security number
Location during accident Member vehicle ◯ Other vehicle ◯ Pedestrian ◯	Describe injury (-ies)		

Passenger(s) and Witness(es)	Name and address	Phone number(s)
Passenger 1		
Passenger 2		
Witness 1		
Witness 2		

Accident description

Other information

Date completed	Electronic signature

Save the blank file on your computer <u>before</u> you fill it in electronically.
When you have saved the final version, attach it to an email and send it to newclaim@vlct.org.

Questions? Please contact us

VLCT PACIF — Claims Division

89 Main Street, Suite 4; Montpelier VT 05602

Phone: (800) 649-7915; Fax: (802) 229-2211