COLLISION DAMAGE CLAIM FORM

IMPORTANT: PLEASE READ THIS FORM CAREFULLY. IF THIS FORM IS NOT FULLY COMPLETED AND APPROPRIATE DOCUMENTATION PROVIDED, IT MAY DELAY THE HANDLING OF YOUR CLAIM.

SECTION 1 - INSURED INFORMATION

NAME OF INSURED	SOCIAL SECURITY NUMBER		DATE OF BIRTH	
STREET ADDRESS	CITY	STATE	ZIP CODE	E-MAIL
GIVE NAME OF CO-INSURED/TRAVELING COMPANION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	CERTIFICATE NUMBER OR PLAN CODE	

SECTION 2 - TRAVEL INFORMATION

AGENCY	ADDRESS	TELEPHONE ( )	FAX ( )
TRAVEL AGENT'S NAME	E-MAIL	BOOKING/RESERVATION NUMBER	TRIP COST
DESTINATIONS		DEPARTURE DATE	RETURN DATE

SECTION 3 - DETAILS OF LOSS

DATE OF LOSS`	TIME OF LOSS	EXACT LOCATION (CITY, STATE, DISTRICT, COUNTY)
NAME OF PERSON DRIVING RENTAL VEHICLE	IS THIS PERSON LISTED ON RENTAL AGREEMENT? ❑ YES ❑ NO	IS THIS PERSON LISTED ON TRAVEL INSURANCE POLICY? ❑ YES ❑ NO
NAME OF RENTAL COMPANY	ADDRESS	TELEPHONE ( )
MAKE OF RENTAL VEHICLE	MODEL	YEAR

WERE THE POLICE NOTIFIED?
❑ YES ❑ NO IF YES, PLEASE PROVIDE NAME OF DEPARTMENT AND REPORT NUMBER

WAS AN ACCIDENT REPORT MADE TO THE RENTAL AGENCY?
❑ YES ❑ NO IF YES, PLEASE PROVIDE COPY

PLEASE DESCRIBE HOW THE DAMAGE OCCURRED TO THE VEHICLE

SECTION 4 - DESCRIPTION OF DAMAGE/LOSS AND AMOUNT CLAIMED

DESCRIPTION	AMOUNT OF BILL	AMOUNT REIMBURSED BY ANY OTHER PARTY	AMOUNT CLAIMED*
*IMPORTANT: DOCUMENTATION SUBSTANTIATING AMOUNTS CLAIMED MUST BE PROVIDED		TOTAL AMOUNT CLAIMED	

SECTION 5 - WITNESSES INFORMATION (NAME, ADDRESS, AND PHONE NUMBER)

NAME	ADDRESS	TELEPHONE	ADDITIONAL INFORMATION

PLEASE COMPLETE OTHER SIDE

SECTION 6 - OTHER DRIVERS INVOLVED

NAME	ADDRESS	TELEPHONE	INSURANCE COMPANY	REPORTED	POLICY NUMBER
				❑ YES ❑ NO	
				❑ YES ❑ NO	
				❑ YES ❑ NO	

WHO DO YOU THINK WAS AT FAULT FOR THE ACCIDENT?	WAS ANYONE CITED BY THE POLICE?

SECTION 7 - AUTHORIZATION

TO ALL INSURERS, COMMON CARRIERS, RENTAL CAR AGENCIES, EMPLOYERS AND GOVERNMENTAL AGENCIES: YOU ARE AUTHORIZED TO GIVE MONUMENTAL GENERAL CASUALTY COMPANY/STONEBRIDGE CASUALTY INSURANCE COMPANY, CSA TRAVEL PROTECTION, ITS AFFILIATES, REINSURERS, ANY AGENT, CONSUMER REPORTING AGENCY OR INDEPENDENT CLAIM ADMINISTRATOR ACTING ON BEHALF OF MONUMENTAL GENERAL CASUALTY COMPANY/STONEBRIDGE CASUALTY INSURANCE COMPANY AND CSA TRAVEL PROTECTION, INFORMATION CONCERNING ANY INSURANCE COVERAGE, TRAVEL ARRANGEMENTS, OR ANY OTHER INFORMATION THAT MAY HAVE BEARING ON THE REQUEST FOR BENEFITS SUBMITTED IN CONJUNCTION WITH THE TRAVEL PROTECTION PLAN.

A COPY OF THIS AUTHORIZATION SHALL HAVE THE SAME AUTHORITY AS THE ORIGINAL.

INSURED'S SIGNATURE	DATE	RESIDENCE TELEPHONE	BUSINESS TELEPHONE
		( )	( )

WARNING AND NOTICE:

Any person who knowingly and with intent to defraud, injure or deceive an insurance company or other person files a statement of claim or application containing any materially false or misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a crime and may be subject to civil penalties, fines, and/or imprisonment.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

BY SUBMITTING THIS CLAIM, I CERTIFY THAT ALL ANSWERS TO THESE QUESTIONS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

INSURED'S SIGNATURE	DATE	RESIDENCE TELEPHONE	BUSINESS TELEPHONE
		( )	( )