



# 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](mailto: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	Describe injury (-ies)		
Member vehicle    Other vehicle    Pedestrian			

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

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

**Accident description**

**Other information**

<b>Date completed</b>	<b>Electronic signature</b>

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Questions? Please contact us  
**VLCT PACIF — Claims Division**  
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Phone: (800) 649-7915; Fax: (802) 229-2211

