

Morga & Medlin Farm & Ranch Program ~ 5701 Lonetree Blvd #109 ~ Rocklin, CA 95765
Phone: 877-500-5507 ~ Fax: 916-663-5634 ~ Email: colettewolf3@gmail.com

CLAIMS PROCEDURES AMERICAN BANKERS

EMERGENCY AFTER HOURS HOTLINE: 800-245-1505

1. FILL OUT THE ATTACHED AUTOMOBILE LOSS NOTICE
2. FAX THE ACCORD CLAIMS FORM TO THE CLAIMS OFFICE 800-224-4170
3. FAX A COPY TO MORGA & MEDLIN 916-663-5634



AUTOMOBILE LOSS NOTICE

DATE (MM/DD/YYYY)

AGENCY	INSURED LOCATION CODE	DATE OF LOSS AND TIME	AM
	CARRIER		PM
	POLICY NUMBER		
	POLICY TYPE		
CONTACT NAME:			
PHONE (A/C, No, Ext):			
FAX (A/C, No):			
E-MAIL ADDRESS:			
CODE:	SUBCODE:		
AGENCY CUSTOMER ID:			

INSURED

NAME OF INSURED (First, Middle, Last)			INSURED'S MAILING ADDRESS		
DATE OF BIRTH	FEIN (if applicable)	MARITAL STATUS			
PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	PRIMARY E-MAIL ADDRESS:			
		SECONDARY E-MAIL ADDRESS:			

CONTACT

NAME OF CONTACT (First, Middle, Last)			CONTACT'S MAILING ADDRESS		
PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL				
WHEN TO CONTACT		PRIMARY E-MAIL ADDRESS:			
		SECONDARY E-MAIL ADDRESS:			

LOSS

LOCATION OF LOSS	POLICE OR FIRE DEPARTMENT CONTACTED
STREET:	
CITY, STATE, ZIP:	REPORT NUMBER
COUNTRY:	
DESCRIBE LOCATION OF LOSS IF NOT AT SPECIFIC STREET ADDRESS:	
DESCRIPTION OF ACCIDENT (Attach ACORD 101, Additional Remarks Schedule, if more space is required)	

INSURED VEHICLE

VEH #	YEAR	MAKE:	BODY TYPE:	PLATE NUMBER	STATE
		MODEL:	V.I.N.:		
OWNER'S NAME AND ADDRESS <input type="checkbox"/> (Check if same as insured)			PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
			PRIMARY E-MAIL ADDRESS:		
			SECONDARY E-MAIL ADDRESS:		
DRIVER'S NAME AND ADDRESS <input type="checkbox"/> (Check if same as owner)			PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
			PRIMARY E-MAIL ADDRESS:		
			SECONDARY E-MAIL ADDRESS:		
RELATION TO INSURED (Employee, family, etc.)	DATE OF BIRTH	DRIVER'S LICENSE NUMBER	STATE	PURPOSE OF USE	USED WITH PERMISSION? (Y/N)
DESCRIBE DAMAGE					
1. WAS A STANDARD CHILD PASSENGER RESTRAINT SYSTEM (CHILD SEAT) INSTALLED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?					Y / N
2. WAS THE CHILD PASSENGER RESTRAINT SYSTEM (CHILD SEAT) IN USE BY A CHILD DURING THE TIME OF THE ACCIDENT?					Y / N
3. DID THE CHILD PASSENGER RESTRAINT SYSTEM (CHILD SEAT) SUSTAIN A LOSS AT THE TIME OF THE ACCIDENT?					Y / N
ESTIMATE AMOUNT:	WHERE CAN VEHICLE BE SEEN?:		WHEN CAN VEHICLE BE SEEN?:		
OTHER INSURANCE ON VEHICLE - CARRIER:			POLICY NUMBER:		

OTHER VEHICLE / PROPERTY DAMAGED NON - VEHICLE?

AGENCY CUSTOMER ID: _____

VEHICLE YEAR	VEHICLE MAKE	VEHICLE MODEL	VEHICLE TYPE	PLATE NUMBER	STATE
DESCRIBE PROPERTY (Other Than Vehicle)					OTHER VEH/PROP INVT (VIN)
CARRIER OR AGENCY NAME		NAC CODE	POLICY NUMBER		
OWNER'S NAME AND ADDRESS		PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
		PRIMARY E-MAIL ADDRESS:			
DRIVER'S NAME AND ADDRESS <input type="checkbox"/> (Check if same as owner)		PRIMARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL		SECONDARY PHONE # <input type="checkbox"/> HOME <input type="checkbox"/> BUS <input type="checkbox"/> CELL	
		PRIMARY E-MAIL ADDRESS:			
DESCRIBE DAMAGE					
ESTIMATE AMOUNT	WHERE CAN DAMAGE BE SEEN BY				

INJURED

NAME & ADDRESS	PHONE (H/C, No)	PBD	BUS	OTH	AGE	EXTENT OF INJURY
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

WITNESSES OR PASSENGERS

NAME & ADDRESS	PHONE (H/C, No)	PBD	OTH	OTHER (Specify)
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

REPORTED BY	REPORTED TO
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REMARKS: (Attach ACORD 101, Additional Remarks Schedule, if more space is required)