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

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

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| 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. |
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| NOTE: If employee was injured, please advise if a Work Comp claim should be entered as well.  | Choose... |
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