

**AUTO LIABILITY TRANSMITTAL SHEET**  
(For use with claims already reported - do not use to submit new claim)

TO: RISK MANAGEMENT/AUTO LIABILITY, 201 East Madison, Ste. 3C, Spfld., IL 62794

FROM:

DATE:

RE: **ADDITIONAL INFORMATION ON CLAIM PREVIOUSLY SUBMITTED**

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STATE DRIVERS NAME:

AGCY/DIV:

SSN:

DEPT FILE NO:

ACCIDENT DATE:

OWNER/DRIVER NAME:

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ATTACHMENTS:

Memo - State employee-----	Yes___ No___
Memo - Investigating officer-----	Yes___ No___
Police Report-----	Yes___ No___-Ordered___
Witness statements-----	Yes___ No___
Estimates from claimant-----	Yes___ No___
Estimates - state vehicle-----	Yes___ No___
Other - please specify -----	Yes___ No___

\_\_\_\_\_  
\_\_\_\_\_

COMMENTS/MISC INFORMATION:

STATE VEHICLE DAMAGE RECOVERY:

AMOUNT EXPECTED:

AMOUNT RECOVERED:

OTHER COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Daytime phone where the state driver may be reached: \_\_\_\_\_

For other agency assistance contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**DO NOT ALTER THE FORMAT OF THIS DOCUMENT**

**AUTO LIABILITY UNIFORM COVER LETTER**

**TO:** RISK MANAGEMENT/AUTO LIABILITY, 201 East Madison, Ste. 3C, Springfield, IL 62794

**FROM: NAME:** \_\_\_\_\_ **AGENCY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**RE: INITIAL REPORT OF VEHICLE ACCIDENT** **\* DENOTES CMS USE ONLY**

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**CLAIM CANNOT BE CONSIDERED AS RECEIVED WITHOUT THIS REQUIRED INFORMATION**

STATE DRIVER'S SOCIAL SECURITY #: \_\_\_\_\_ AGENCY/DIV CODE (FIVE DIGIT #): \_\_\_\_\_  
STATE DRIVER'S NAME: \_\_\_\_\_ DEPT FILE NO: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_  
STATE DRIVER'S HOME ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
STATE DRIVER'S CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
ACCIDENT DATE: \_\_\_\_\_ \*DATE RECEIVED BY CMS \_\_\_\_\_

WAS STATE DRIVER IN THE COURSE OF EMPLOYMENT: yes no  
LICENSE # ON VEHICLE \_\_\_\_\_  
DOES CLAIM INVOLVE: Property damage: y / n Bodily injury: y / n Wrongful death: y / n DUI: y / n  
ACCIDENT STATE: \_\_\_\_\_ CITY: \_\_\_\_\_  
STREET 1: \_\_\_\_\_ STREET 2: \_\_\_\_\_  
WAS STATE DRIVER TICKETED: yes no (if yes - describe) \_\_\_\_\_  
IS VEHICLE OWNED BY: STATE /EMPLOYEE /RENTAL CO /OTHER: (circle one)  
DESCRIBE WHAT HAPPENED:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**OTHER OWNER/DRIVER INFORMATION**

DRIVER'S NAME \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
STREET: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
OWNER (IF OTHER THAN DRIVER): \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
STREET: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

AUTO: YR: \_\_\_\_\_ MAKE: \_\_\_\_\_ MODEL: \_\_\_\_\_  
VIN: (if known) \_\_\_\_\_ LIC: \_\_\_\_\_

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**PASSENGER INFORMATION**

PASSENGER NAME: \_\_\_\_\_ HOME PHONE : \_\_\_\_\_ WORK  
PHONE: \_\_\_\_\_  
PASSENGER STREET: \_\_\_\_\_  
PASSENGER CITY: \_\_\_\_\_  
WAS PASSENGER IN: STATE VEH OTHER VEH (CIRCLE CHOICE)

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STATE VEHICLE DAMAGE: \_\_\_\_\_ EXPECTED RECOVERY \_\_\_\_\_

**COVER LETTER WITH SR -1 MUST BE REPORTED TO CMS WITHIN 7 CALENDAR DAYS AFTER ACCIDENT**  
IL401-1579 revised 8/99