

Please return this form to: msnewclaims@ccmsi.com or Fax to: (601) 899-0160

CLAIM REPORTING FORM

County.		
Address:	City/St/Zip:	
Contact Person:	Phone No.:	
OTHER THAN AUTO ACCIDENT		
Name:		
Home Address:	Alt Phone: ()	
	Description of Accident:	
AUTO ACCIDENT	Involving ☐ County owned ☐ Non-County owned	
Name of County Driver:		
	City/St/Zip:	
Home Phone: () -	Alt Phone: ()	
Date of Loss: / / Time of Loss: :	am/pm County Vehicle Tag No.:	
	ModelColor	
	ke Model Color	
	Wodel	
Owner's Name: Home Address: Location of Proporty (for inspection):	City/St/Zip:	
Location of Property (for inspection).		
INJURY (Non-County Employees)		
Name:	Name:	
Home Address:		
City/St/Zip:	City/St/Zip:	
Description of Injury:	Description of Injury:	
Injured person taken to doctor/hospital? ☐ Yes ☐ No	Injured person taken to doctor/hospital? ☐ Yes ☐ No	
If yes, where?:		
Name:		
Home Address:	Home Address:	
City/St/Zip:	City/St/Zip:	
Description of Injury:		
Injured person taken to doctor/hospital? ☐ Yes ☐ No	Injured person taken to doctor/hospital? ☐ Yes ☐ No	
If yes, where?:		
<u></u>	yes, where::	
WITNESS OR PASSENGER		
Name:	_	
Home Address:	City/St/Zip:	
Phone: ()	Alt Phone: ()	
Danier consolication while forms		
Person completing this form:	Date Completed:	