Business Insurance Claim/Loss Reporting Procedures

Automobile Claims Reporting

- Incidents or claims involving DSU Peterbilt & GMC, Inc. owned, leased, loaned, or rented vehicles are to be reported to the employee's manager, who in turn should report the incident to the President, General Manager, and the Accounting Supervisor – Scott Goodrich (x3017). The manager should also report incidents or claims over $250 for light duty and $500 for heavy duty using the forms mentioned below to Safeco Insurance at 1-877-538-1920.
- A blank Oregon Accident Report Form (Copy Attached) should be placed in each DSU owned, leased, loaned, and rented vehicle. For Washington accidents, you must contact the local authorities to have them issue an accident report. Copies of Washington and Oregon Forms must be forwarded to the President, General Manager, Accounting Supervisor and Safeco as soon as reasonably possible after the incident (No more than 72 hours after the incident).
- If the incident occurs on company property, the procedures above should be followed.
- If the incident occurs off company property, the appropriate law enforcement agency should be contacted as well as following the procedures above.
- DSU's insurer does not cover damage to personal belongings of vehicle occupants.
- DSU's insurer does not cover damage to personal vehicles of employees used on company business. The insurance company covering the vehicle is considered primary for both auto liability and physical damage exposures.

General Liability Claims Reporting

- Incidents involving bodily injury or property damage to an employee or third party require immediate notification to the Department Manager, who in turn should report to the President, General Manager, Accounting Supervisor (x3017) and Payroll/HR (x3018). The Accounting Supervisor and Payroll/HR are responsible for notifying the appropriate insurance carrier.

Property and Equipment Loss Reporting

- DSU has property insurance to protect against direct physical loss or damage to its real or personal property over $500 - $1,000 from events such as theft, fire, windstorm, lightening, hail, explosion, or flood. Any applicable deductibles are the responsibility of the department incurring the loss.
- It is the Department Manager's responsibility to notify the President, General Manager, and the Accounting Department of a claim by filing a Property Loss Report. (Copy Attached) The manager should also report incidents or claims over $1,000 to Safeco Insurance at 1-877-538-1920.
- For equipment losses, a copy of the original purchasing documents PO or Invoice is required to value the claim. Please check with the Accounting Department for the documents.
- A police report must be filed on all claims involving theft and/or vandalism, or on any other claim of a suspicious nature.
- DSU is not responsible for the loss of or damage to personal property of employees. It is expected that these items would be insured through an individual's home insurance policy.

Cash Losses

- All cash losses should be reported to the police, President, General Manager, and to the Accounting Department. The Department Manager should also report incidents or claims over $1,000 to Safeco Insurance at 1-877-538-1920. The Accounting Department may perform an audit to verify the amount of cash loss and make a recommendation as to the possible reimbursement of the amount of loss.

Peterbilt Floored Vehicle Losses

- Please see attached memorandum below.

PETERBILT & GMC INC.

PROPERTY LOSS REPORT

Employee's Name _____

Department _____ DSU Phone No. _____

Department Address _____

Manager's Name _____ DSU Phone No._____

Location of Loss _____

Police or Fire Dept. Loss Reported to _____

Detailed Description of Loss of Damage

Date: _____Time: _____

Items Damaged, Lost or Stolen: _____

_____

Circumstances of Loss or Damage: _____

_____

Witnesses: _____

_____

_____

Please forward copies to: **President**
General Manager
Accounting Department

MEMORANDUM

PACCAR FINANCIAL
INSURANCE SERVICES

DATE: May 10, 2006

TO: Dealers with Insurance Coverage through PFC's Floor plan Program

FROM: Bill Fehr, Director of PACCAR Financial Insurance Services

SUBJECT: Floor Plan Insurance for 2006

Cc: Area Ops Managers, Wholesale Specialists, AISMs

Attached is the 2006 General Provisions of Physical Damage Insurance notification that outlines the floor plan insurance program provided by Sentry Insurance.

- Please note the same deductible of $1,000 per vehicle for each loss applies as in previous policies, however the maximum deductible has been increased from $7,500 to $15,000.
- Also, there is a limit of $6,000,000 per any one location (any locations with an address closer than one mile will be considered one location).
- We identified all locations with floored inventory in excess of $6,000,000 as of January 1, 2006 and have obtained a written exception for each location.

If you have inventory in excess of $6,000,000 in any different location during the course of the year, please let us know so we can report it to Sentry.

If you have any questions, please feel free to contact Dawn Szymanowski at 425-468-7092.

Bill Fehr
Director of PACCAR Financial Insurance Services

SENTRY INSURANCE
A MUTUAL COMPANY

PACCAR FINANCIAL

SENTRY INSURANCE A MUTUAL COMPANY
STEVENS POINT, WISCONSIN
POLICY NUMBER 90-01961-02 (01/01/2006 to 01/01/2007)

GENERAL PROVISIONS OF PHYSICAL DAMAGE INSURANCE

This is to advise that all motor vehicles and trailers including all attachments, appurtenances and equipment therefor and special merchandise (but not including repair parts) in which PACCAR Financial Corp. (hereinafter referred to as "PFC") has an insurable interest, all of which being held by a dealer for sale, lease or rental, are insured under a policy of physical damage insurance. The insurance is written by Sentry Insurance a Mutual Company authorized to do business throughout the United States and Canada. The interest of the dealer, as well as the interest of PFC in the equipment is protected. The insurance applies while the insured property is in the United States or Canada.

This advice is not a contract of insurance and PFC does not undertake any responsibility as an insurer. The rights of all parties are governed by the policy.

A brief summary of some of the provisions of the insurance follows:

The insurance covers all direct physical loss of or damage to the property insured, except as related in the exclusions below. A deductible of $1,000 per vehicle applies to each loss, but a maximum deductible of $15,000 applies per occurrence.

The insurance covers from the time the dealer takes possession of the property, continuously until delivery under a sale to an ultimate purchaser or until delivery under a lease or rental agreement to an ultimate lessee, or renter or PFC's interest is terminated, whichever first occurs.

The liability of the insurer is limited to Six Million Dollars ($6,000,000) for property insured under this policy at any one location* as a result of a single loss, disaster or casualty, whether for partial or total loss or salvage charges or expenses, or all combined unless a specific written exception is obtained. [*NOTE: Floor Plan locations with an address closer than one mile will be considered as one location in calculating aggregate exposure per location.]

THIS INSURANCE DOES NOT APPLY:

(a) To any covered motor vehicle while rented or leased, unless such damage is the result of other loss covered by this insurance.

(b) To tires, unless

(i) Loss be coincident with and from the same cause as other loss covered by this insurance; or

(ii) Damage by fire, or stolen.

(c) To loss to

(i) Any device or instrument designed for the recording, reproduction of sound, unless such device or instrument is permanently installed by the factory in the covered motor vehicle.

(ii) Any tape, wire, record disc or other medium for use with any device or instrument designed for the recording, reproduction, or recording or reproduction of sound.

(iii) Sound receiving - C.B. receiver. Any sound receiving equipment designed for use as a citizens band radio, two-way mobile radio or telephone or scanning monitor receiver including its antennas and other accessories, unless permanently installed in the dash or console opening normally used by the auto manufacturer for the installment of a radio.

(iv) Any dealer options or enhancements installed by the dealer.

(d) To loss or damage due to conversion, embezzlement or secretion of any auto by any person entrusted with the auto.

(e) To loss resulting from the dealer voluntarily parting with title to any covered auto whether or not induced to do so by any fraudulent scheme, trick, device or false pretense.

SUBROGATION

In the event of any payment under the policy Sentry Insurance a Mutual Company is subrogated to all of the rights of PFC and the dealer to recovery against any person or organization and PFC and the dealer must execute and deliver instruments and papers and do whatever else is necessary to secure such rights. Neither PFC nor the dealer shall do anything after loss to prejudice such rights.

IN THE EVENT OF LOSS IMMEDIATE NOTICE THEREOF MUST BE GIVEN TO THE SENTRY INSURANCE HOME OFFICE CLAIMS DEPARTMENT, P. O. Box 8032, Stevens Point, Wisconsin 54481-8032 (phone 800-739-3344). Such notice in ALL CASES should show the serial number of equipment, dealer's name and address, the loss date and an itemized estimate of damage, how caused, and where equipment can be inspected. Payment of loss is to be made to PFC and it is responsible for proper payment to a dealer. Claims will be adjusted on the basis of actual cash value at the time of loss, but not to exceed the maximum amount floor planned at anytime on each specific damaged vehicle.

PACCAR FINANCIAL

FLOOR PLAN INSURANCE

When an Accident or Loss Occurs.....

- Report Accidents or losses immediately even if all information is not available.
- Make first report to Sentry Claims Service at 1-800-739-3344
- Telephone reporting is available 24 hours a day/365 days a year.
- When you call, a customer service representative will be available to guide you through reporting the accident or loss. See attached First Report.
- Please have your ***dealer number*** and ***factory code*** available and ***PACCAR's account # 90-01961***.
- A police report is ***required*** to report theft/vandalism claims. Submit to:

  Sentry Claims Service
  1421 Strongs Avenue
  P.O. Box 8032
  Stevens Point, WI 54481
  claimsmail@sentry-direct.com
  fax 1-800-726-8631

- The Sentry claim number, claim office, and toll-free telephone number will be provided to you prior to the completion of your call.

What to Expect.....

- Claim is logged into Sentry's system and assigned to adjuster
- Contact within 24 hours (business day hours) of your initial call
- Adjuster will ask you to submit the MSO
- Sentry notifies PFC Insurance Services of the claim
- Sentry may assign an appraiser
- After the initial report, you may speak to our adjuster, Teri Jirous:

  1-800-638-8763 extn 9278 / fax 715-346-9708
  Teri.jirous@sentry.com

OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Tear this sheet off your report, read and carefully follow the directions.

ONLY drivers involved in an accident resulting in any of the following MUST file an *Accident & Insurance Report:*

- **Damage to your vehicle is over $1500**
- **Injury (No matter how minor)**
- **Death**
- **Damage to any one person's property over $1500**
- **Any vehicle involved in an accident and is towed from the scene as a result of damages**

Oregon law requires these reports be filed within 72 hours of the accident. If you are not able to file within the 72 hours, submit it as soon as possible. If you fail to report the accident to DMV, it may result in suspension of your driving privileges. If the police department files a police report, you are **still** required to file your own Accident and Insurance Report with DMV. If you are an out-of-state resident, you are **still** required to file your own Accident Report with DMV. DMV does not determine fault in an accident, but does post the accident to the driving record of those drivers required to report, unless the vehicle is parked. If you have questions, please call the Accident Unit at (503) 945-5098.

INSTRUCTIONS

PRINT OR TYPE ALL INFORMATION. (Use black or dark blue ink and press firmly.)

- Complete both sides of the form.
- If additional vehicles were involved in the accident, complete the attached *Supplemental Report* (Form 735-32B), or on a blank piece of paper, write all the information as requested in Section 4, the "Other Driver" Section.
- Mail the form to Accident Reporting Unit, DMV, 1905 Lana Ave NE, Salem OR 97314, or deliver it to any DMV office.
- DMV Headquarters will verify the insurance information submitted. Complete the insurance section or a suspension of your driving privileges may occur.

SECTION 1

DATE, LOCATION AND TIME — Clearly identify the date, location and time of the accident. The correct date, location and time is critical to processing your report. If you are unsure of the county, contact any local law enforcement agency for assistance.

SECTION 2

YOUR VEHICLE (# 1) — DMV will consider your accident uninsured if you do not complete **ALL** of this section. You must list the insurance company name (not agency) and policy number that provided **liability coverage** for your operation of the vehicle you were driving at the time of the accident. Note the coverage is for **liability insurance**, not collision or comprehensive coverage. DMV will verify this information with the insurance company. If the insurance company denies the coverage, DMV will suspend your Oregon driving privileges.

SECTION 3

Answer all of the questions in Section 3. DMV will use the information provided in these questions to code the accident. It is important for you to understand "principal purpose of driving" and "paid to drive." These include ONLY persons employed or being paid for the purpose of driving, NOT driving to reach a destination to perform a service. Property includes, but is not limited to, fixed or real property, landscaping, signs, parked vehicles, and animals.

NOTE TO COMMERCIAL MOTOR VEHICLE OPERATORS: In addition to this report, Oregon Administrative Rule requires that Form 735-9229, *Motor Carrier Crash Report*, **MUST** be filed within 30 days of a commercial motor vehicle accident when there is a FATALITY, INJURY (requiring treatment away from the scene), or when a vehicle is TOWED from the scene because of damage. Form 735-9229 (attached on back) MUST be submitted with *Oregon Traffic Accident and Insurance Report* (Form 735-32) to DMV. For questions regarding the *Motor Carrier Crash Report*, call (503) 986-3507.

SECTION 4

OTHER VEHICLE (# 2) — Completion of this information will help DMV match all driver's accident reports more efficiently. If additional vehicles were involved in the accident, complete attached *Supplemental Report* (Form 735-32B).

SECTION 5

DESCRIPTION AND SIGNATURE — Describe what happened. It is important for you to sign and date the form.

COMPLETING AND FILING REPORT

OTHER SIDE OF FORM — Complete the other side of the form. Information collected from both sides of this form is used by DMV and other officials in making valuable transportation decisions about the roadway systems and driver safety.

YOUR COPY — Under Oregon law ORS 802.220 (5), DMV can not provide you a copy of your *Oregon Traffic Accident and Insurance Report.* If you wish to have a complete copy of your report (front and back), **you** will need to make a copy for **your** records.

RECEIPT — Attached is a PINK courtesy copy of your report. After you have completed both sides of the form, tear the PINK copy off for your records. If you want a receipt, bring the form, with the PINK copy, to a DMV office and have your copy validated. **Without a receipt, you will have no proof of submitting a report.**

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY CAN NOT REQUIRE REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

TOTALED VEHICLE NOTICE

DEFINITIONS AND INSTRUCTIONS FOR TOTALED VEHICLES

IF YOUR ACCIDENT HAS RESULTED IN A "TOTALED" VEHICLE, YOU ARE REQUIRED BY LAW TO FOLLOW APPROPRIATE INSTRUCTIONS IN THIS NOTICE.

DEFINITION OF "TOTALED" VEHICLE

"Totaled Vehicle" or "Totaled" as defined in Oregon law (ORS 801.527) means:

- A vehicle that is declared a total loss by an insurer who is obligated to cover the loss or a vehicle that the insurer takes possession of or title to.
- A vehicle that has sustained damage that is not covered by an insurer and the estimated cost to repair the vehicle is equal to at least 80% of the retail market value prior to the damage. "Retail market value" is defined as the amount shown in publications used by financial institutions (banks or lenders) in this state.
- A vehicle that is stolen, if it is not recovered within 30 days of theft and the loss is not covered by an insurer. In this situation, you must notify DMV within 60 days of the theft.

▼ FOLLOW THESE INSTRUCTIONS IF YOUR VEHICLE IS TOTALED ▼

If your vehicle is totaled, in addition to completing the accident report, follow the instruction that is applicable to your case. ***Either:***

1. SURRENDER the title to the insurer if the damage is covered by an insurer who declares the vehicle to be a "total loss," and the insurer takes possession of the vehicle; ***or***

2. SURRENDER the title to DMV and apply for salvage title if the damage is covered by an insurer who declares the vehicle to be a "total loss," but you keep possession of the vehicle; ***or***

3. SURRENDER the title to DMV and apply for salvage title if the damage was not covered by an insurer and the estimated cost of repair is at least 80% of the retail market value of the vehicle before the damage; ***or***

4. NOTIFY DMV that your vehicle has been totaled if, for some reason, you are unable to obtain the title for surrender. You must provide DMV with a signed statement which includes:
   - A description of the vehicle which includes the year model, make, plate number and vehicle identification number.
   - A statement indicating the vehicle has been totaled.
   - A statement that you are unable to obtain the title and why.

DO NOT SUBMIT THE TITLE WITH THE ACCIDENT REPORT. You can obtain the *Application for Salvage Title* (Form 735-229) from any DMV office, by calling (503) 945-5000, or on-line at www.oregondmv.com. Application instructions and fee information are on the back of the form 735-229. If you have questions about salvage titles, call (503) 945-5122.

NOTE: It is a Class A misdemeanor with a penalty of imprisonment and/or fine if you fail to comply with the above requirements. (ORS 819.012)

OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT

Complete this form ONLY if your accident happened on a highway or premises open to the public, and resulted in **any** of the following: 1) More than $1500 in damage to your vehicle; 2) More than $1500 in damage to any one person's property; 3) A vehicle towed from the scene as a result of damages; 4) Injury to any person (no matter how minor the injury); or, 5) the death of any person. **COMPLETE BOTH SIDES.**

SECTION 1

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY

DO NOT WRITE IN THIS SPACE Accident Number _____

ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route) | MILE POST

☐ WITHIN _____ FEET N S E W NAME OF NEAREST INTERSECTING ROAD
☐ NEAR _____ MILES N S E W

☐ WITHIN _____ FEET N S E W NAME OF NEAREST CITY / TOWN
☐ NEAR _____ MILES N S E W

TYPE OF ACCIDENT - The accident involved one or more of the following: **(Mark all that apply)**

☐ Two vehicles	☐ ATV / Snowmobile	☐ Parked vehicle
☐ More than two vehicles	☐ Motorcycle	☐ Overturned vehicle
☐ Fatality	☐ Motorized Scooter	☐ Animal
☐ Bicycle	☐ Personal (assisted) mobility device	☐ Fixed object / personal property
☐ Pedestrian	☐ Train	☐ Other _____

SECTION 2 (YOUR VEHICLE # 1)

Complete ALL of this section. If you fail to do so, your driving privileges may be suspended. You **MUST** list the insurance company (not agency) and policy number that provided liability coverage for the vehicle you were driving.

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSENUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S RESIDENCE ADDRESS	CITY	STATE	ZIP CODE	☐ IF ADDRESS CHANGE

MAILING ADDRESS (IF DIFFERENT THAN RESIDENCE)	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS ☐ SAME	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME **(NOT AGENCY)** AND ADDRESS	CITY	STATE	ZIP CODE

POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

SECTION 3

Was your vehicle's damage more than $1500?	☐ **YES** ☐ **NO**
Other person's vehicle damage more than $1500?	☐ **YES** ☐ **NO**
Was there damage to any one person's property more than $1500?	☐ **YES** ☐ **NO**
Was a vehicle involved in the accident towed from the scene as a result of damages?	☐ **YES** ☐ **NO**
Did the accident occur while you were driving your employer's vehicle?	☐ YES ☐ NO
Were you driving on your job and being paid for the principal purpose of driving?	☐ YES ☐ NO
Were you being paid to drive and/or deliver persons or property?	☐ YES ☐ NO
Were you operating a government owned vehicle marked for transporting mail in accordance with government rules?	☐ YES ☐ NO
Were you operating an authorized emergency vehicle?	☐ YES ☐ NO
Were you operating a commercial motor vehicle requiring you to have a commercial driver license?	☐ YES ☐ NO
a) Were you transporting hazardous material?	☐ YES ☐ NO
Were occupants of the other vehicle(s) injured?	☐ YES ☐ NO
Did a police officer come to the scene?	☐ YES ☐ NO
If yes, name of police department: _____ ☐ City ☐ County ☐ State Police	
Was a citation issued to you?	☐ YES ☐ NO

SECTION 4 (OTHER VEHICLE # 2)

DRIVER'S NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSENUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS ☐ SAME	CITY	STATE	ZIP CODE

INSURANCE COMPANY NAME **(NOT AGENT)** AND ADDRESS

POLICY NUMBER	VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

IF ADDITIONAL VEHICLES WERE INVOLVED IN THE ACCIDENT, USE ATTACHED *SUPPLEMENTAL REPORT* (Form 735-32B).

SECTION 5

DESCRIBE WHAT HAPPENED:

I certify all information given on this report is true and accurate to the best of my knowledge.

SIGNATURE OF PERSON MAKING REPORT	PRINTED NAME OF PERSON MAKING REPORT	DAYTIME PHONE #	DATE SIGNED
X		( )	

YOU INTENDED TO...

- ☐ Go straight ahead
- ☐ Make right turn
- ☐ Make left turn
- ☐ Make "U" turn
- ☐ Back–Up
- ☐ Enter driveway (also mark left or right turn)
- ☐ Remain stopped in traffic
- ☐ Enter parked position
- ☐ Slow or Stop
- ☐ Leave driveway (also mark left or right turn)
- ☐ Start in traffic lane
- ☐ Leave parked position
- ☐ Remain parked
- ☐ Overtake and pass

YOUR VEHICLE

- ☐ Passenger car, pickup, van
- ☐ Military vehicle
- ☐ Taxicab
- ☐ Emergency vehicle
- ☐ Any of the above and trailer
- ☐ Private or public agency transit vehicle
- ☐ Bus
- ☐ School bus
- ☐ Other publicly-owned veh.
- ☐ Motorcycle
- ☐ Motor–scooter/bike
- ☐ Personal (assisted) mobility device
- ☐ Truck tractor & semi trailer
- ☐ Truck/truck tractor
- ☐ Other truck combination
- ☐ Farm tractor/farm equip.

WEATHER CONDITIONS

- ☐ Clear
- ☐ Raining
- ☐ Snowing
- ☐ Fog
- ☐ Other

ROAD SURFACE

- ☐ Dry
- ☐ Wet
- ☐ Snowy
- ☐ Icy
- ☐ Other

LIGHT CONDITIONS

- ☐ Daylight
- ☐ Dawn or dusk
- ☐ Darkness (lighted)
- ☐ Darkness (unlighted)
- ☐ Other

YOUR RESIDENCE

- ☐ Local resident (within 25 miles of accident site)
- ☐ Residing elsewhere in state
- ☐ Non–resident of this state:
  - ☐ College student
  - ☐ Military
  - ☐ Temporary job

YOU WERE HEADED

☐ North ☐ East ☐ South ☐ West

On: _____ (name of street, road or route)

OTHER DRIVER WAS HEADED

☐ North ☐ East ☐ South ☐ West

On: _____ (name of street, road or route)

WITNESS INFORMATION:

_____

_____

If this accident involved a pedestrian or bicyclist, complete the following:

☐ **PEDESTRIAN NAME** ☐ **BICYCLIST NAME**

Pedestrian or bicyclist was going: ☐ N ☐ S ☐ E ☐ W

ALONG OR ACROSS: (name of street, road or route)

From:

To:

EXAMPLE: (**From**: NE corner **To:** SE corner (or) **From**: East side **To:** West side, etc.)

Sex and age of pedestrian / bicyclist:
☐ Male ☐ Female Age: _____

Extent of pedestrian / bicyclist injury:
☐ Deceased ☐ Possible injury
☐ Incapacitated ☐ No apparent injury
☐ Visible injury

Pedestrian / bicyclist action: (mark one)
- ☐ Crossing at intersection or crosswalk
- ☐ Crossing **not** at intersection or crosswalk
- ☐ Walking / riding in roadway with traffic
- ☐ Walking / riding in roadway **against** traffic
- ☐ Standing in roadway
- ☐ Pushing or working on vehicles in roadway
- ☐ Other working in road
- ☐ Playing in road
- ☐ Hitchhiking
- ☐ Not in roadway
- ☐ Other_____ (specify)

DRIVER AND PASSENGER INJURY AND SAFETY EQUIPMENT INFORMATION

SAFETY EQUIPMENT CODES
WRITE (in column **C**)

0 No seat belt available
1 Seat belt available but NOT used
2 Seat belt available and in use
3 Child restraint device available
4 Child restraint device in use
5 Child restraint device not available
6 Helmet NOT in use
7 Helmet in use
8 Air bag deployed
9 Air bag available - NOT deployed
10 Air bag NOT available

INJURY CODE FOR OCCUPANTS
WRITE (in column **D**)

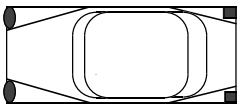
1 Deceased as a result of the accident
2 Incapacitated - unconscious, could not walk, broken or distorted limbs, etc.
3 Visible injury - lump, abrasion cuts
4 Momentary unconsciousness, complaint of pain, nausea, limping
5 No apparent injury

SEAT POSITION	PASSENGER'S NAMES (your vehicle)	A SEX	B AGE	C SFTY EQP	C AIR BAG	D INJURY
DRIVER						
FRONT CENTER						
FRONT RIGHT						
MIDDLE * LEFT						
MIDDLE * CENTER						
MIDDLE * RIGHT						
REAR LEFT						
REAR CENTER						
REAR RIGHT						

* Use **only** for vehicles with middle row of seats (i.e., vans, SUVs, etc.)

Vehicle Damage

FRONT

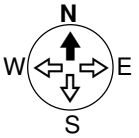


USE ARROW TO SHOW FIRST IMPACT (SHADE IN DAMAGED AREA)

- ☐ Vehicle towed
- ☐ Rollover
- ☐ Under car
- ☐ Totaled
- ☐ Unknown

Your Vehicle (No. 1) damage: $ _____ .
Other Vehicle (No. 2) damage: $ _____ .

Diagram



Number each vehicle: 1 2
Show path by:
Show pedestrian/bicyclist by:
Show railroad tracks by:

(name of street, road or route)

(name of street, road or route)

(name of street, road or route)

GF13 rev. 6/27/06

SUPPLEMENTAL REPORT
OREGON TRAFFIC ACCIDENT

Supplemental for more than two drivers involved in the crash.
Attach this form to your OREGON TRAFFIC ACCIDENT AND INSURANCE REPORT.

ACCIDENT DATE	DAY OF WEEK M T W TH F S SN	TIME OF DAY AM PM	COUNTY

ROAD ON WHICH ACCIDENT OCCURRED (Name of street, road or route) | MILE POST

DO NOT WRITE IN THIS SPACE

VEHICLE #3

INSURANCE COMPANY NAME (NOT AGENCY)	POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
☐ SAME			

VEHICLE #4

INSURANCE COMPANY NAME (NOT AGENCY)	POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
☐ SAME			

VEHICLE #5

INSURANCE COMPANY NAME (NOT AGENCY)	POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
☐ SAME			

VEHICLE #6

INSURANCE COMPANY NAME (NOT AGENCY)	POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
☐ SAME			

VEHICLE #7

INSURANCE COMPANY NAME (NOT AGENCY)	POLICY NUMBER

VEHICLE IDENTIFICATION NUMBER	VEHICLE PLATE NUMBER	STATE	YEAR	MAKE & MODEL

OTHER DRIVER'S FULL NAME (LAST, FIRST, MIDDLE)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH	SEX

DRIVER'S ADDRESS	CITY	STATE	ZIP CODE

VEHICLE OWNER'S NAME AND ADDRESS	CITY	STATE	ZIP CODE
☐ SAME			

OREGON DEPARTMENT OF TRANSPORTATION
TRANSPORTATION DEVELOPMENT DIVISION
CRASH ANALYSIS & REPORTING
555 13TH ST NE SUITE 2
SALEM OR 97301-4178
TELEPHONE: (503) 986-3507
FAX: (503) 986-4249

MOTOR CARRIER CRASH REPORT

INSTRUCTIONS: IF YOU CHECKED A BOX UNDER THE QUALIFYING VEHICLE COLUMN AND A BOX UNDER THE CRITERIA COLUMN, COMPLETE THE REMAINDER OF THE FORM AND SUBMIT TO THE ADDRESS SHOWN ABOVE. IF NO CIRCUMSTANCES LISTED UNDER THE CRITERIA COLUMN APPLY, YOU ARE NOT REQUIRED TO SUBMIT THIS FORM.

QUALIFYING VEHICLE

- ☐ COMMERCIAL TRUCK (GVWR OVER 10,000 LBS OR ACTUAL WT AT TIME OF CRASH EVEN IF GVWR IS SET UNDER 10,000 LBS)
- ☐ HAZARDOUS MATERIAL PLACARD
- ☐ COMMERCIAL BUS (DESIGNED FOR 8 OR MORE PASSENGERS)
- ☐ FARM VEHICLE (4 AXLES OR MORE) OPERATED FOR HIRE (80,000 LBS OR LESS)
- ☐ FARM VEHICLE (4 AXLES OR MORE OPERATED OVER 80,000 LBS (FARMER'S FARM USE ONLY)

CRITERIA

- ☐ ANY PERSON SUSTAINING A FATALITY (WITHIN 30 DAYS OF THE ACCIDENT)
- ☐ ANY PERSON SUSTAINING INJURIES REQUIRING TREATMENT AWAY FROM THE SCENE
- ☐ ANY VEHICLE INCURRING DISABLING DAMAGE REQUIRING REMOVAL FROM THE SCENE BY A TOW TRUCK OR ANOTHER MOTOR VEHICLE

MOTOR CARRIER NAME	US DOT NUMBER	AUTHORITY/FILE NUMBER	
ADDRESS	CITY	STATE	ZIP CODE

DRIVER INFORMATION

DRIVER NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	LENGTH OF EMPLOYMENT YEARS / MONTHS
CDL /DL NUMBER	STATE	LICENSE CLASS ☐ A ☐ B ☐ C ☐ D ☐ M	EXPIRATION DATE OF MEDICAL CERTIFICATE

COMPLETE THE FOLLOWING TWO QUESTIONS AS IF DOING A RECAP OF HOURS IN TIME DOCUMENTS AT TIME OF THE ACCIDENT.

AT TIME OF THE ACCIDENT, TOTAL HOURS DRIVING SINCE LAST OFF-DUTY PERIOD. _____	TOTAL HOURS ON DUTY DURING THE PREVIOUS (FILL OUT ONE ONLY, BASED ON TIME DOCUMENTS)	7 CONSECUTIVE DAYS _____ 8 CONSECUTIVE DAYS _____
DOES YOUR DRIVER HAVE A MEDICAL WAIVER ☐ YES ☐ NO	TYPE OF WAIVER (SIGHT, DIABETES, AMPUTEE, ETC.)	

DRIVER INJURY INFORMATION

YOUR DRIVER KILLED ☐YES ☐NO	YOUR DRIVER INJURED ☐YES ☐NO	RELIEF DRIVER KILLED ☐YES ☐NO	RELIEF DRIVER INJURED ☐YES ☐NO	TOTAL NUMBER OF PASSENGERS ____KILLED ____ INJURED

OTHER DRIVER INJURY INFORMATION

TOTAL NUMBER OF OTHER DRIVERS ____KILLED ____ INJURED	TOTAL NUMBER OF OTHER PASSENGERS ____KILLED ____ INJURED	TOTAL NUMBER OF PEDESTRIANS ____KILLED ____ INJURED	TOTAL NUMBER OF BICYCLISTS ____KILLED ____ INJURED

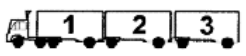
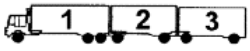
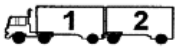
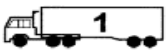
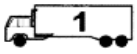
OTHER MOTOR CARRIER INFORMATION (IF 2 OR MORE MOTOR CARRIERS WERE INVOLVED)

MOTOR CARRIER NAME	VEHICLE LICENSE # AND STATE	DRIVER'S NAME	DRIVER'S LICENSE # AND STATE

MOTOR CARRIER VEHICLE INFORMATION

YEAR	MAKE	UNIT NUMBER	TRUCK/TRACTOR/BUS LICENSE PLATE NO. & STATE	TOTAL NO. OF AXLES INCLUDING TRAILERS

VEHICLE TYPE (SELECT APPROPRIATE TYPE)

- ☐ 1  Triples (tractor with 3 trailers
- ☐ 2  Triples (truck with 2 trailers)
- ☐ 3  Straight truck-full trailer
- ☐ 4  Doubles (any)
- ☐ 5  Standard Tractor/Semi Trailer
- ☐ 6  Straight Truck
- ☐ 7  Bobtail
- ☐ 8  Saddlemount
- ☐ 9  Heavy Haul
- ☐ 10  Bus/Van (8 or more passenger capacity)
- ☐ 11  Auto/Pickup

☐ **CONTINUED ON REVERSE**

CARGO BODY TYPE (CIRCLE ONE)

VAN FLATBED TANKER CONTAINER POLE DUMP BELLY-DUMP CAR CARRIER LIVESTOCK
MOBILE HOME TOTER PASSENGER DROP-BOX GARBAGE BULK-HOPPER MIXER SADDLEMOUNT
WRECKER FIXED LOAD HEAVY HAUL UTILITY

TOTAL LENGTH OF VEHICLE/COMB	TOTAL WIDTH OF VEHICLE OR CARGO	CARGO WEIGHT	GROSS VEHICLE WEIGHT

COMMODITY INFORMATION

COMMODITY BEING TRANSPORTED AT TIME OF CRASH		
WAS A HAZARDOUS COMMODITY BEING HAULED ☐YES ☐NO	WAS HAZARDOUS MATERIAL RELEASED FROM THE VEHICLE CARGO(NOT A FUEL RELEASE) ☐YES ☐NO	HAZARD CLASS

CRASH INFORMATION

LOCATION OF CRASH (NEAREST CITY OR TOWN)	HIGHWAY AND MILEPOINT/STREET/COUNTY ROAD	DIRECTION OF YOUR VEHICLE (CIRCLE) N S E W
DATE OF CRASH	TIME ☐AM ☐PM	DAY OF THE WEEK (CIRCLE ONE) MON TUES WED THU FRI SAT SUN

CONDITIONS AT TIME OF ACCIDENT

WEATHER (CIRCLE ONE) 1. CLEAR 2. RAIN 3. SNOW 4. CLOUDY 5. SLEET 6. FOG 7. OTHER _____

ROAD SURFACE (CIRCLE ONE) 1. DRY 2. WET 3. SNOWY 4. ICY 5. OTHER _____

LIGHT CONDITION (CIRCLE ONE) 1. DAY 2. DAWN 3. DUSK 4. ARTIFICIAL LIGHTS 5. DARK 6. OTHER _____

DESCRIBE WHAT HAPPENED BY CHECKING ALL BOXES THAT APPLY. YOUR VEHICLE IS ALWAYS NO.1. IF OTHER VEHICLES WERE INVOLVED, COMPLETE COLUMNS 2 & 3 TO CORRESPOND TO THE ACTIONS OF THE SAME NUMBERED VEHICLES LISTED ABOVE UNDER "OTHER DRIVER INFORMATION".

VEHICLES 1	2	3	ACTION	VEHICLES 1	2	3	ACTION	VEHICLES 1	2	3	ACTION
			SLOWING - STOPPING				PASSING				JACKKNIFE
			STOPPED				CHANGING LANES				OVERTURN
			REAR-END				SIDESWIPE				SEPARATION OF UNITS
			BACKING				HEAD-ON				FIRE
			MAKING RIGHT TURN				SKIDDING				EXPLOSION
			MAKING LEFT TURN				VEHICLE OUT OF CONTROL				CARGO SHIFT
			MAKING U TURN				ROLL-AWAY				CARGO SPILL (HAZARDOUS)
			PROCEEDING STRAIGHT				CONTROLLED RR CROSSING				CARGO SPILL (NON-HAZARDOUS)
			INTERSECTION				UNCONTROLLED RR CROSSING				OTHER (DEER, GUARDRAIL, ETC)
			ENTERING TRAFFIC (FROM SHOULDER, MEDIAN, PARKING STRIP OR PRIVATE DRIVE)				RAN OFF ROAD				_____

DID YOUR VEHICLE STRIKE A PARKED VEHICLE ☐YES ☐NO	WAS YOUR PARKED VEHICLE STRUCK BY ANOTHER VEHICLE ☐YES ☐NO

DESCRIPTION OF ACCIDENT BY CARRIER OFFICIAL

NAME AND TITLE OF PERSON SIGNING REPORT	TELEPHONE NUMBER(S)
SIGNATURE I CERTIFY THE INFORMATION PROVIDED IS TRUE AND ACCURATE	DATE