

Date: April 1, 2018

Re: Claim Reporting Procedure

Thank you for your placing your commercial auto insurance with the TIP National Transportation Program.

Attached hereto please find an electronic ACORD form, together with Accident Report Form, which should be filled in as completely as possible and submitted immediately as follows:



Phone #: 24/7 Emergency: (800) 537-8023
[all claims involving bodily injury]

Email: claims@tritonclaims.com

Fax #: (770) 645-0665 or
Fax #: (770) 645-2910

Address: P.O. Box 527
Alpharetta, Georgia 30009

Claim Service issues should be directed to John J. Fleming, III at via toll-free number (800) 537-8023, or Cell # (678) 910-4621, or via email to jfleming@tritonclaims.com 24/7.

Should the need arise, we look forward to being of service to you!

Cordially yours,

TRITON CLAIM MANAGEMENT, LLC

John J. Fleming, III

If claim involves bodily injury, please call (800) 537-8023 now

ACCIDENT SCENE REPORT

DATE: _____

SIGNATURES

Employee: _____

Supervisor: _____

OPERATOR:

Name: _____

Dept.: _____

Age: _____

SSN: _____

DESCRIPTION OF MEMBER VEHICLE:

Year, Make & Model: _____

License Tag No.: _____

Serial #: _____

Nature of Damage: _____

ACCIDENT INFORMATION:

Date: _____

Time: _____

Where did it occur? _____

Weather at time of accident: _____

Condition of road: _____

Rate of Speed (Yours): _____

Other Vehicle: _____

Was warning given? _____

Investigating Officer: _____

Police report #: _____

DESCRIPTION OF ACCIDENT: _____

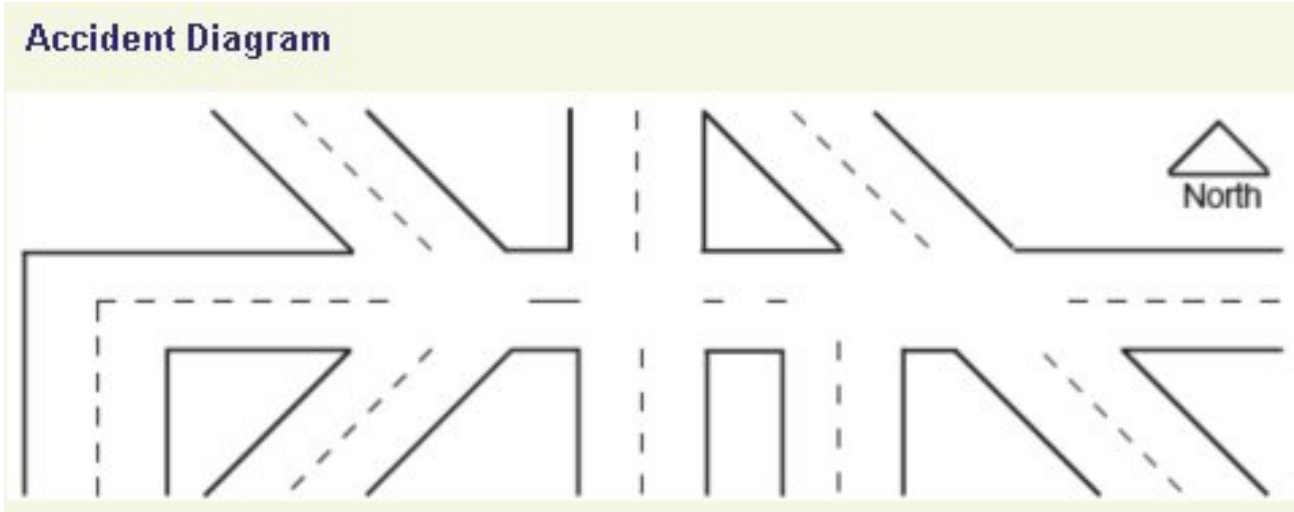
IF LOSS INVOLVES BODILY INJURY CALL (800) 537-8023 NOW

PLEASE COMPLETE AND FAX TO (770) 645-2910 OR EMAIL TO claims@tritonclaims.com

If claim involves bodily injury, please call (800) 537-8023 now

DIAGRAM OF ACCIDENT:

Complete the following diagram showing direction & positions of the vehicles involved, designating clearly point of impact. Show the names of the streets:



OTHER VEHICLE INFORMATION:

Name of Registered Owner: _____

Address: _____

Name of Driver: _____

Address of Driver: _____

Insurance Company: _____

Policy #: _____ Phone #: _____

Home Phone #: _____ Cell Phone #: _____

Driver's License #: _____ Vehicle Tag: _____

Agent Name & #: _____

Nature of Damage: _____

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INJURED PERSONS:

1. Name: _____ Age: _____
Address: _____
2. Name: _____ Age: _____
Address: _____
3. Name: _____ Age: _____
Address: _____

IMPORTANT WITNESSES!

1. Name: _____ Phone #: _____
Address: _____
2. Name: _____ Phone #: _____
Address: _____
3. Name: _____ Phone #: _____
Address: _____

NAME OF PASSENGERS:

1. Name: _____ Age: _____
Address: _____
2. Name: _____ Age: _____
Address: _____
3. Name: _____ Age: _____
Address: _____

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PRINT ONE FOR EACH WITNESS:

THE LOCAL GOVERNMENT INSURANCE TRUST REQUIRES THAT ALL MOTOR VEHICLE ACCIDENTS BE REPORTED ACCURATELY. YOUR AID TO OUR DRIVER IN THE PERFORMANCE OF THIS DUTY IS VERY APPRECIATED			
NAME:		PHONE #:	
ADDRESS:			
CITY/TOWN		STATE	ZIP:
Did you see the accident? YES/NO	Were you involved in the accident? YES/NO	Were you injured? YES/NO	Was anyone injured? YES/NO
What Happened?			

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If Bodily Injury Involved Call (800) 537-8023 NOW!
Triton Claim Department

ACORD™ AUTOMOBILE LOSS NOTICE										DATE	
PRODUCER	PHONE (A/C, No, Ext): [Agent's Ph #]				COMPANY	NAIC CODE:			MISCELLANEOUS INFO (Site & location code)		
[Agency Name]					POLICY NUMBER [Policy No]		REFERENCE NUMBER		CAT #		
CODE:		SUB CODE:			EFFECTIVE DATE	EXPIRATION DATE	DATE OF ACCIDENT AND TIME		PREVIOUSLY REPORTED		
AGENCY CUSTOMER ID							[Date of Loss]	[Time of Loss]			
INSURED					CONTACT			<input type="checkbox"/> CONTACT INSURED			
NAME AND ADDRESS				SOC SEC #:	NAME AND ADDRESS				WHERE TO CONTACT		
[Insured Name/Address]					[Insured Contact Person Name]				WHEN TO CONTACT		
RESIDENCE PHONE (A/C, No)		BUSINESS PHONE (A/C, No, Ext)			RESIDENCE PHONE (A/C, No)		BUSINESS PHONE (A/C, No, Ext)				
LOSS											
LOCATION OF ACCIDENT (Include city & state)						AUTHORITY CONTACTED:		VIOLATIONS/CITATIONS			
DESCRIPTION OF ACCIDENT						REPORT #:					
INSURED VEHICLE											
VEH #	YEAR	MAKE:			BODY TYPE:			PLATE NUMBER	STATE		
		MODEL:			V.I.N.:						
OWNER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):		BUSINESS PHONE (A/C, No, Ext):			
DRIVER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):		BUSINESS PHONE (A/C, No, Ext):			
<input type="checkbox"/> (Check if same as owner)											
RELATION TO INSURED (Employee, family, etc)		DATE OF BIRTH	DRIVER'S LICENSE NUMBER			STATE	PURPOSE OF USE		USED WITH PERMISSION?		
DESCRIBE DAMAGE		ESTIMATE AMOUNT \$	WHERE CAN VEHICLE BE SEEN?			WHEN CAN VEH BE SEEN?		OTHER INSURANCE ON VEHICLE?			
PROPERTY DAMAGED											
DESCRIBE PROPERTY (If auto, year, make, model, plate #)					OTHER VEH/PROP INS?	COMPANY OR AGENCY NAME:					
						POLICY #:					
OWNER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):		BUSINESS PHONE (A/C, No, Ext):			
OTHER DRIVER'S NAME & ADDRESS						RESIDENCE PHONE (A/C, No):		BUSINESS PHONE (A/C, No, Ext):			
<input type="checkbox"/> (Check if same as owner)											
DESCRIBE DAMAGE		ESTIMATE AMOUNT \$	WHERE CAN DAMAGE BE SEEN?								
INJURED											
NAME & ADDRESS				PHONE (A/C, No)		PED, INS VEH, OTH VEH	AGE	EXTENT OF INJURY			
WITNESS OR PASSENGERS											
NAME & ADDRESS				PHONE (A/C, No)		INS VEH or OTH VEH	OTHER (Specify)				
REMARKS (Include adjuster assigned)											
REPORTED BY		REPORTED TO			SIGNATURE OF INSURED			SIGNATURE OF PRODUCER			