Confederated Tribes of Colville Reservation
Property & Casualty Insurance

P.O. Box 150 • Nespelem, WA • 99155 • Ph: 509-634-2146 • Fax: 509-634-2194

CLAIM FOR DAMAGES

MAIL OR DELIVER ORIGINAL CLAIM TO:

Property, Casualty & Fleet Management
10 Lakes Street
Post Office Box 150
Nespelem, Washington 99155

PLEASE TYPE OR PRINT IN INK

CLAIM INFORMATION

Program Name: _____ Phone #: _____

Program Funding Source: _____ Tribal _____ 638 _____ Both _____Other: _____

Employee name: _____
(Last Name) (First) (Middle)

Employee Driver's License Number: _____

Physical program address: _____

Mailing address (if different): _____

Employee daytime phone numbers: _____
(Home) (Work) (Cell)

Employee email address: _____

INCIDENT INFORMATION

Date of Incident: _____ Time: _____ am/pm

If the incident occurred over a period of time, date of first and last occurrences:

From: _____ Time: _____ am/pm

To: _____ Time: _____ am/pm

Location of Incident: _____

Explanation of Incident/Accident: _____

_____

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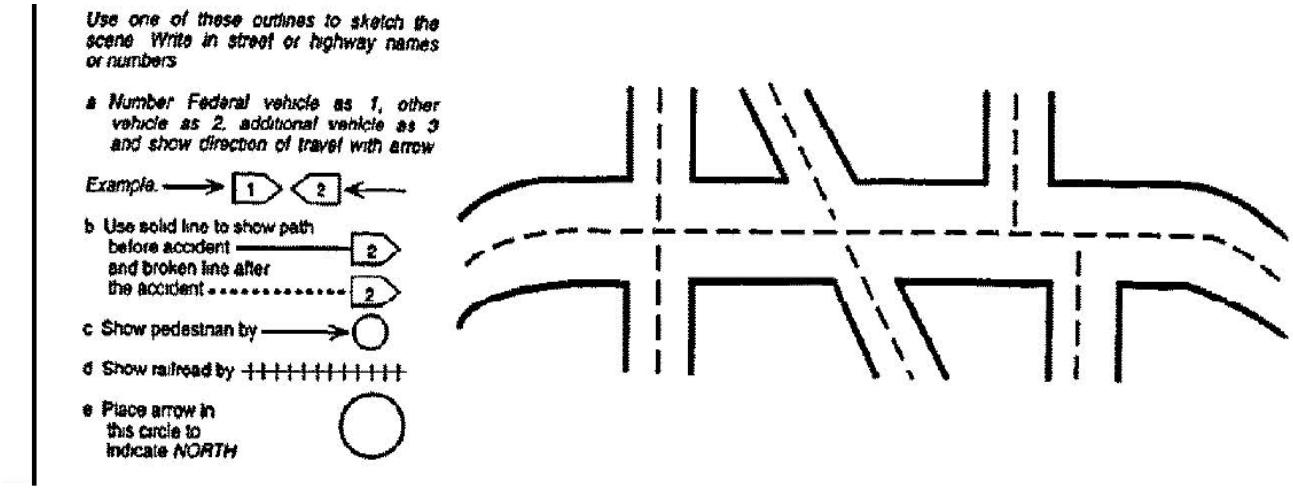
Indicate on this diagram, how the accident happened?



Names, addresses, and contact numbers of all persons involved in, or witness to, this incident:

Name	Address	Phone #

If Vehicle, please complete the following:
Vehicle year: _____ Make: _____ Model: _____ License: _____
Vehicle VIN#: _____
Seat Belts Used: Yes ☐ No ☐

Names, addresses, and telephone numbers of all CCT programs or employees having knowledge of this incident:

Name	Address	Phone #

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Names, addresses, and telephone numbers of any other individual not mentioned above who may have knowledge regarding any liability issues involved in this incident, or knowledge of the claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

Name	Address	Phone #

Describe the cause of the injury or damages.

	Explain the extent of property loss or medical treatments necessary as a result of this incident attach additional sheets if necessary.
Damages	
Injury(ies)	
Property Loss	

Has the incident been reported to law enforcement, safety or security personnel? If so; when and to whom:

Name	Program	Date Notified

Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and

Name	Organization and Address	Phone Number

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Other Vehicle/Driver's Information:

Driver's Name: _____

Driver's Phone #:_____

Driver's license Number: _____

Driver's Address:_____

Driver's Phone Number: _____Cell#:_____Home#:_____

Vehicle year: _____Make: _____Model: _____License: _____

Vehicle VIN#: _____

Insurance Company Name: _____

Insurance Company Phone #:_____

Insurance Company Policy #_____

I, employee believes claim damages from the Confederated Tribes of the Colville Reservation in the amount of $_____

I certify that the information on this form is correct to the best of my knowledge and belief.

_____ _____

Signature of Reporting Person | Title

_____ _____

Address | City, State & Zip Code

_____

Phone Number

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Details of Trip during which the accident occurred to be completed by Supervisor:

Origin	Destination
Exact Purpose of Trip	

Trip Began	Date	Time	Accident Occurred	Date	Time

Authority for the Trip was given to the Driver	Was There any Deviation from Direct Route?
Orally: Yes ☐ Written ☐	No ☐ ☐ Yes (Explain)
Was the Trip made within established working hours?	Did the Driver while enroute, engage in any activity other than for which the trip was authorized?
Yes ☐ ☐ No (Explain)	No ☐ ☐ Yes (Explain)

Completed by Driver's Supervisor
Did the accident occur within the employee's scope of duty? No ☐ ☐ Yes (Explain)
Comments:

Name of Supervisor (Please Print): _____

Title of Supervisor: _____

Supervisor's Phone Number: _____

Supervisor's Signature: _____Date: _____