OFFICE OF MOTOR VEHICLES

P.O. BOX 64886, BATON ROUGE, LA 70896-4886
1-225-925-6146 www.expresslane.org

SAFETY RESPONSIBILITY CLAIM FORM

In accordance with the provisions of R.S. 32:871, an insured motorist, property owner or injured person may make a claim for the recovery of property damages and /or injuries resulting from a motor vehicle accident that occurred in Louisiana. If your vehicle was involved in this accident, you must provide proof that your vehicle was covered by liability insurance or other security at the time of the accident.

DATE AND LOCATION OF ACCIDENT

DATE OF ACCIDENT (MM/DD/YY)	LOCATION OF ACCIDENT	CITY	PARISH

PERSON SUBMITTING CLAIM (Your Vehicle)

DRIVER'S NAME (FIRST, MIDDLE, LAST)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH (MM/DD/YY)

DRIVER'S ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP	SEX
				☐ MALE ☐ FEMALE

OWNER OF VEHICLE	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH (MM/DD/YY)

OWNER'S ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP	SEX
				☐ MALE ☐ FEMALE

VEHICLE (YEAR AND MAKE)	VEHICLE IDENTIFICATION NUMBER (VIN)	STATE	LICENSE PLATE NUMBER

LIABILITY INSURANCE INFORMATION AT TIME OF ACCIDENT OR ATTACH INSURANCE CARD/OTHER SECURITY

NAME OF INSURANCE COMPANY (NOT AGENCY OR BROKERAGE)

POLICY NUMBER	POLICY PERIOD (MM/DD/YY TO MM/DD/YY)
	_____ TO _____

PERSON(S) CLAIM IS AGAINST (Other Vehicle)

DRIVER'S NAME (FIRST, MIDDLE, LAST)	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH (MM/DD/YY)

DRIVER'S ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP	SEX
				☐ MALE ☐ FEMALE

OWNER OF VEHICLE	DRIVER'S LICENSE NUMBER	STATE	DATE OF BIRTH (MM/DD/YY)

OWNER'S ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP	SEX
				☐ MALE ☐ FEMALE

VEHICLE (YEAR AND MAKE)	VEHICLE IDENTIFICATION NUMBER (VIN)	STATE	LICENSE PLATE NUMBER

DAMAGE TO VEHICLE

AMOUNT

DAMAGE TO OTHER PROPERTY (Telephone poles, fences, etc.)

DESCRIPTION	AMOUNT

INJURIES AND/OR DEATHS CAUSED BY THE ACCIDENT

NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	
						☐ UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	
						☐ UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	
						☐ UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	
						☐ UNDER AGE 18

As a result of this motor vehicle accident, I believe I am entitled to recovery of the indicated property damages and/or medical expenses from the person(s) this claim is against, and that I have not released said person(s). I certify by signing below that the information entered by me on this document is true and correct to the best of my knowledge.

DATE (MM/DD/YY)	PRINT NAME	SIGN NAME
	X	**X**