

# RISK MANAGEMENT

*Loss Prevention and Claims Administration for State Agencies*

Presented **May 8, 2017** for the Interagency  
Advisory Council on Loss Prevention

## AUTOMOBILE LIABILITY: ACCIDENT REPORTING

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**Dept. of Financial Services**  
**Division of Risk Management**  
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# Bureau of State Liability and Property Claims

- Responsible for investigation & resolution/settlement of liability & property claims involving or against state agencies & universities
- Adjusts (investigates, evaluates, denies, settles, or defends) claims filed against state of Florida agencies under these coverages:

- |                               |                               |
|-------------------------------|-------------------------------|
| ➤ General liability           | ➤ Employment discrimination   |
| ➤ <b>Automobile liability</b> |                               |
| ➤ Federal Civil Rights        | ➤ Court-awarded attorney fees |




- Enters notices of claims & service of process filed against subdivisions of the state of Florida (counties) into the claims administration system and provides affidavits on these as requested

# Statement of Claim

- Form DFS-Do-262
- Located on DRM website
- Information includes:

- ✓ Accident details
- ✓ Injury details

 **DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

**STATEMENT OF CLAIM**

Department: \_\_\_\_\_ Our Claim No.: \_\_\_\_\_  
Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ D/OB: \_\_\_\_\_

Name of Spouse or Parent if Minor: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM \_\_\_\_\_ PM  
Place of Accident—Indicate Location By Address \_\_\_\_\_

Statement of How Accident Occurred and the Basis of This Claim (Use Additional Sheet if Necessary)

\_\_\_\_\_

Name & Address of Person(s) Present at Time of Accident (Use Additional Sheet if Necessary)

1. \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
2. \_\_\_\_\_ Telephone No.: \_\_\_\_\_  
3. \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Describe Motor Vehicle Owned by You or Member of Household Including License Number (State None if No Listing)

\_\_\_\_\_

Name of Insurance Company on the Above Vehicles

\_\_\_\_\_

Were you Injured?  Yes  No If Yes, Complete the Following:  
Describe Injury: \_\_\_\_\_

\_\_\_\_\_

Page 1 of 2  
DFS-DO-262, Rev. 11/05

List Doctors & Hospital Giving Treatment (Including Complete Name & Address)

\_\_\_\_\_

\_\_\_\_\_

Amount of Total Doctor Bill (Remove Bills Must Be Attached) \_\_\_\_\_ Hospital Bill (Remove Bill Must Be Attached) \_\_\_\_\_

Are You Receiving Medical Treatment at Present?  Yes  No  
Were You in the Course of Employment?  Yes  No  
Did You Lose Income?  Yes  No If Yes, List Employers of Past 3 Years

1. Name of Company or Person \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

All claim of lost wages must include signed statement from employer itemizing date and pay lost.

Date Disability Began \_\_\_\_\_ Date Returned to Work \_\_\_\_\_  
Did you receive damage to motor vehicle or personal property? (List description in detail. Give license number.)

\_\_\_\_\_

List Any Other Expense (Nurses, Drugs Must Have Supporting Bills)

\_\_\_\_\_

Do you have any existing claim for workmen's compensation, personal injury protection, or other claim of personal injury?  
 Yes  No If yes, list date, place, type of accident, and injury.

\_\_\_\_\_

List any accident in which you received any type of injury in the past 5 years, if none, indicate  NONE.  
(Use back for complete list).

Identify Policy Authority Investigating \_\_\_\_\_  
Their Location \_\_\_\_\_

Sworn to and subscribed before me \_\_\_\_\_ Signed \_\_\_\_\_  
This \_\_\_\_\_ day of \_\_\_\_\_

NOTARY PUBLIC, STATE OF FLORIDA AT LARGE  
My Commission Expires: \_\_\_\_\_

DFS-DO-262, Rev. 11/05  
Page 2 of 2

# Statement of Accident

- Form DFS-Do-261
- Located on DRM website
- Information includes:

- ✓ Accident details
- ✓ Vehicle information
- ✓ Injury details
- ✓ Description of property damage

 **DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

STATEMENT OF ACCIDENT

DATE OF ACCIDENT	TIME	
WHERE DID ACCIDENT HAPPEN?		
NUMBER OF PERSONS IN YOUR CAR	NUMBER OF PERSONS IN OTHER CAR	
MAKE OF YOUR CAR	LICENSE PLATE NUMBER	
YEAR MODEL		
OWNER'S NAME AND ADDRESS		
DRIVER'S NAME	AGE	
LICENSE NUMBER		
DRIVER'S ADDRESS		
WHAT PARTS OF YOUR CAR WERE DAMAGED?		
WHERE CAN CAR BE SEEN?		
WHAT COMPANY CARRIES YOUR AUTOMOBILE INSURANCE?		
WERE YOU INJURED?	WAS ANYONE INJURED?	
GIVE NAME, AGE AND ADDRESS OF INJURED PERSON(S)		
NATURE OF INJURIES		
NAME AND ADDRESS OF DOCTOR		
NAME AND ADDRESS OF HOSPITAL		
WHERE DOES INJURED PERSON WORK?		
MAKE OF OTHER CAR	LICENSE PLATE NUMBER	
OWNER'S NAME AND ADDRESS		
RATE OF SPEED AND DIRECTION OF TRAVEL		
	YOUR VEHICLE	OTHER VEHICLE
EXPLAIN FULLY HOW ACCIDENT OCCURRED		
(IF ADDITIONAL SPACE IS NEEDED ATTACH SEPARATE SHEET)		
DESCRIBE PROPERTY DAMAGE (IF OTHER THAN AUTOMOBILE)		

DFS-DO-261  
Revised 11/05  
Rule 69H-2.008

# Automobile Accident Report

- Form DFS-Do-261
- Located on DRM website
- Information includes:

- ✓ Insured agency
- ✓ Insured auto & drive details
- ✓ Accident details
- ✓ Damage to property of others
- ✓ Injured persons
- ✓ Accident diagram
- ✓ Witness list

**DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

**AUTOMOBILE ACCIDENT REPORT**

State Liability Claims  
Tallahassee, Fl. 32399-0338 RM File #:

<b>INSURED STATE AGENCY</b>	Department
	Business, Institution or District Location and Address
<b>INSURED AUTO AND DRIVER</b>	Year: _____ Make: _____ Model: _____ Driver: _____ Phone No.: _____ Employed by: _____ Purpose of Use at Time of Accident: _____ Amount of Damage to Vehicle: _____
	Date of Accident or Loss: _____ Location of Accident: _____ Police Authority Investigating: _____
	Owner of Property Damage: _____ Phone No. _____ Address: _____ Driver of Other Vehicle: _____ Address: _____ Phone No. _____ Driver's License No.: _____ If Automobile, Year: _____ Make: _____ Model: _____ Kind of Property and Extent of Damage: _____ Insurance Carrier: _____

DFS-Do-261, Rev. 11/05  
Rule 69H-2.008

**DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone No. \_\_\_\_\_

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

**PERSONS INJURED**

Nature and extent of injuries: 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

If Doctor was called, give name: \_\_\_\_\_ Address: \_\_\_\_\_  
Where was injured person taken: \_\_\_\_\_  
By whom: \_\_\_\_\_

(USE BACK FOR ADDITIONAL COMMENTS)

Show on diagram position each car, vehicle, or injured person, indicating direction by arrow

SIDEWALK

CENTER SIDEWALK

**IMPORTANT**  
If street or view obstructed in any way, indicate where and how; also indicate any street cars and traffic signal or sign.

DFS-Do-261, Rev. 11/05  
Rule 69H-2.008

**DEPARTMENT OF FINANCIAL SERVICES**  
*Division of Risk Management*

Explain fully how accident occurred:

Name of Witness	Address	Phone No.	State where witness was at time of accident


Date: \_\_\_\_\_ Name of Person Filing Report: \_\_\_\_\_  
Name of Person Taking Report: \_\_\_\_\_ Telephone Number of Caller: \_\_\_\_\_

DFS-Do-261, Rev. 11/05  
Rule 69H-2.008

# General Liability Loss Report

- Form DFS-Do-1403
- Located on DRM website
- Information includes:

- ✓ Insured agency
- ✓ Accident details
- ✓ Injury details
- ✓ Property damage

 <b>DEPARTMENT OF FINANCIAL SERVICES</b> <i>Division of Risk Management</i>									
<b>GENERAL LIABILITY LOSS REPORT</b>									
Department of Financial Services Division of Risk Management State Liability Claims Larson Building Tallahassee, FL 32399-0338									
RM File No.: _____ (Do not complete)									
<b>INSURED AGENCY</b>	Department: _____ Division and Location: _____ Bureau, Institution, or District: _____								
<b>ACCIDENT</b>	Date: _____ Time: _____ Location: _____ Type of Claim:   Bodily Injury: _____   Property Damage: _____ Medical Malpractice: _____   Other: _____ Description: _____								
<b>INJURED PERSON</b>	Name: _____ Age: _____ Telephone No.: _____ Address: _____ City: _____ State: _____ Occupation & Employer: _____ Why on Premises: _____ Nature & Extent of Injury: _____ <small>(List additional injured persons on back of form.)</small>								
<b>PROPERTY DAMAGE</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">Owner &amp; Address:</td> <td style="width: 40%;">Telephone No.:</td> </tr> <tr> <td>Description of Property:</td> <td></td> </tr> <tr> <td>Describe Damage:</td> <td></td> </tr> <tr> <td colspan="2">When &amp; where can property be inspected:</td> </tr> </table>	Owner & Address:	Telephone No.:	Description of Property:		Describe Damage:		When & where can property be inspected:	
Owner & Address:	Telephone No.:								
Description of Property:									
Describe Damage:									
When & where can property be inspected:									
DFS-Do-1403 Revised 11/05 Rule 69H-2.008									

<b>WITNESSES</b>	<table border="1" style="width: 100%;"> <tr> <th style="width: 30%;">Name</th> <th style="width: 30%;">Address</th> <th style="width: 40%;">Telephone No.</th> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>	Name	Address	Telephone No.									
Name	Address	Telephone No.											
<b>POLICE REPORT</b>	Identify Police Authority Investigating: _____ Their Location: _____ (USE BACK FOR ADDITIONAL COMMENTS)												
	Date of Report: _____ Signature of person filing report: _____ Telephone No.: _____												
<small>(List additional injured persons here.)</small>													
<b>INJURED PERSON</b>	Name: _____ Age: _____ Telephone No.: _____ Address: _____ City: _____ State: _____ Occupation & Employer: _____ Why on Premises: _____ Nature & Extent of Injury: _____												
<b>INJURED PERSON</b>	Name: _____ Age: _____ Telephone No.: _____ Address: _____ City: _____ State: _____ Occupation & Employer: _____ Why on Premises: _____ Nature & Extent of Injury: _____												
<b>INJURED PERSON</b>	Name: _____ Age: _____ Telephone No.: _____ Address: _____ City: _____ State: _____ Occupation & Employer: _____ Why on Premises: _____ Nature & Extent of Injury: _____												
ADDITIONAL COMMENTS: _____ _____ _____													
DFS-Do-1403 Revised 11/05 Rule 69H-2.008													

# What to Do in Case of an Automobile Accident: "Know Before Your Go" Brochure

- Located on DRM website
- Lists actions to take if involved in an auto accident
- Follow 911 emergency procedures
- Report employee injury to supervisor & AmeriSys
- Have accident investigated by law enforcement
- Do not discuss accident details with anyone other than law enforcement
- Obtain any additional information
- Fill out information on form
- Notify Division of Risk Management

**In The Event Of An Accident Complete The Information Below**

Data of Accident:  
Location of Accident: \_\_\_\_\_

Occupants of Vehicles or Pedestrians Involved:

1. Name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
In Your Vehicle ( ) Other Vehicle ( ) Pedestrian ( )  
Was this person injured? Yes ( ) No ( )

2. Name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
In Your Vehicle ( ) Other Vehicle ( ) Pedestrian ( )  
Was this person injured? Yes ( ) No ( )

Witnesses at Scene of Accident:

1. Name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
City & State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Name and Department Location of Law Enforcement Officer Investigating the Accident: \_\_\_\_\_

Other Driver's Insurance Information:

Automobile Insurance Carrier Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**WHAT TO DO IN CASE OF AN AUTOMOBILE ACCIDENT "KNOW BEFORE YOU GO"**

**Chief Financial Officer**  
**JEFF ATWATER**  
FLORIDA DEPARTMENT OF FINANCIAL SERVICES

Florida Department of Financial Services  
Division of Risk Management  
200 East Gaines Street  
Tallahassee, FL 32399-0338

**WHAT TO DO IN CASE OF AN AUTOMOBILE ACCIDENT "KNOW BEFORE YOU GO"**

**Safety 1st**

**If You Are Involved In An Automobile Accident**

- Report any accident immediately to your supervisor in accordance with your agency's procedures.
- Have the accident investigated by law enforcement.
- Get the names, addresses, and telephone numbers of any witnesses to the accident.
- Contact Risk Management immediately at (850) 413-3122.
- Don't promise to pay anything.
- At the scene of the accident, do not discuss details of the accident with anyone except the investigating law enforcement officer.
- Obtain a copy of the accident report, if available, and forward it to the Division of Risk Management. Also, complete the information on the back of this brochure.
- Obtain information about the other driver(s) from the investigating law enforcement officer.
- Provide the officer your Agency/University automobile liability policy number as below:

**YOUR AGENCY/UNIVERSITY NAME** \_\_\_\_\_

(Agency) \_\_\_\_\_

(Agency Head) \_\_\_\_\_

**AUTOMOBILE LIABILITY POLICY #** \_\_\_\_\_

**REPORT ACCIDENT TO:**  
**DIVISION OF RISK MANAGEMENT**  
(850) 413-3122

**Safety Tips**

- Plan your trip before you leave.
- Know where you are going.
- Know the routes you plan to take.
- Know how long it will take to arrive.
- Allow sufficient time – avoid having to rush.
- Check the vehicle's tires, brakes, headlights, horn, windshield wipers, and rear-view mirrors before you leave.

**Seat Belts Do Save Lives So Buckle Up-It's The Law!**  
Management Services Rule 605-1.012 requires mandatory use of seat belts: "Failure to utilize seat belts or occupant restraint system shall be considered improper use of a vehicle and shall subject employees to disciplinary action."

**Place All Work Materials In The Trunk!**  
...such as books, papers, reports, audiovisual equipment and newspapers. Automobile seats were designed for people.

**Know And Obey All Traffic Laws!**  
Speed limits, traffic signs and signals were designed with your safety in mind.

**If You Get Tired Or Sleepy, Stop and Rest!**

**Texting and Dialing a Cell Phone Kills!**  
Avoid taking your eyes off the road for any reason.

**Look Before You Back Up!**  
Accidents while backing up are the major cause of accidents involving State of Florida vehicles.

**Turn On Your Headlights!**  
At sundown and during bad weather, such as rain or fog.

**Know Your Vehicle**  
Return Abut!

Questions?





Thank You

For additional information, please contact:

TORT claims North of  
Orange County:

Jimmy Glisson, Administrator  
North Tort Claims Unit  
Division of Risk Management  
Florida Dept. of Financial Services  
(850)413-4874  
[Jimmy.Glisson@myfloridacfo.com](mailto:Jimmy.Glisson@myfloridacfo.com)

TORT claims Orange County and  
South:

Kelly Hagenbeck, Administrator  
South Tort Claims Unit  
Division of Risk Management  
Florida Dept. of Financial Services  
(850)413-4866  
[Kelly.Hagenbeck@myfloridacfo.com](mailto:Kelly.Hagenbeck@myfloridacfo.com)

For Federal Civil Rights &  
employment discrimination  
claims statewide:

Chris Taul, Administrator  
Federal Civil Rights Claims Unit  
Division of Risk Management  
Florida Dept. of Financial  
Services  
(850)413-4858  
[Chris.Taul@myfloridacfo.com](mailto:Chris.Taul@myfloridacfo.com)

Or visit our website at

<http://www.fldfs.com/Division/Risk/>

**RISK MANAGEMENT**

*Loss Prevention and Claims Administration for State Agencies*