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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Bureau of State Liability and Property Claims

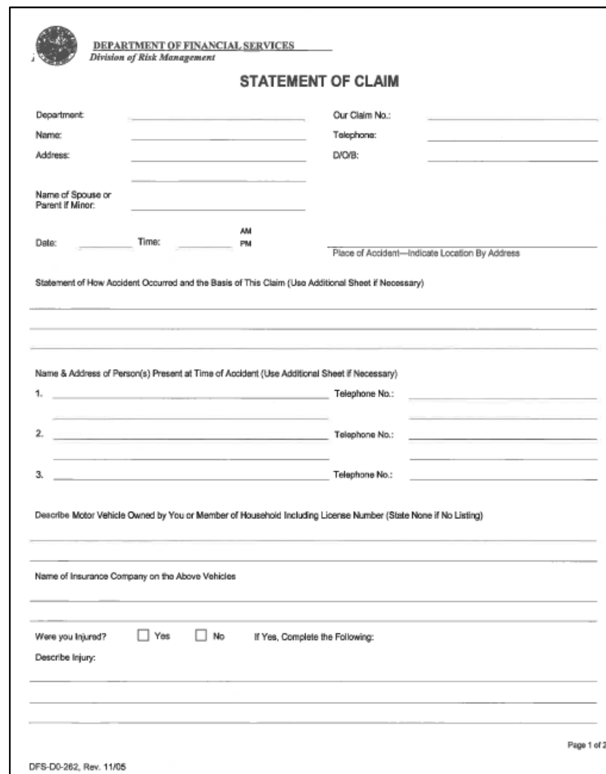
- Responsible for investigation & resolution/settlement of liability & property claims involving or against state agencies & universities
- Adjusts (investigates, evaluates, denies, settles, or defends) claims filed against state of Florida agencies under these coverages:

- General liability
- **Automobile liability**
- Federal Civil Rights
- Employment discrimination
- 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-D0-262
- 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/O/B: ______

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-D0-262, Rev. 11/05

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

Amount of Total Doctor Bill (Itemized Bills Must Be Attached) ______ Hospital Bill (Itemized 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:

Page 2 of 2

DFS-D0-262, Rev. 11/05

Statement of Accident

- Form DFS-D0-261
- 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-D0-261
Revised 11/05
Rule 69H-2.008

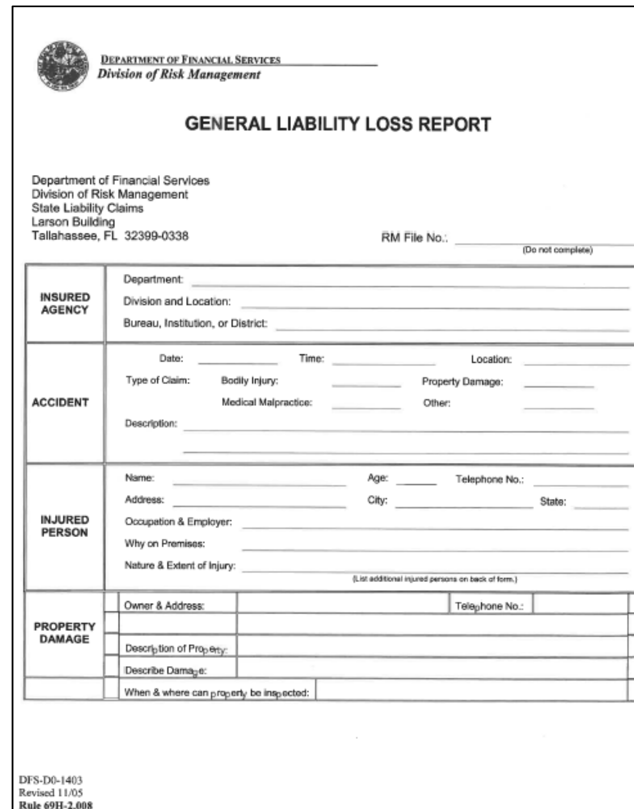
Automobile Accident Report

- Form DFS-D0-261
- 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

General Liability Loss Report

- Form DFS-D0-1403
- Located on DRM website
- Information includes:

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



DEPARTMENT OF FINANCIAL SERVICES
Division of Risk Management

GENERAL LIABILITY LOSS REPORT

Department of Financial Services
Division of Risk Management
State Liability Claims
Larson Building
Tallahassee, FL 32399-0338

RM File No.: ______ (Do not complete)

INSURED AGENCY	Department: ______ Division and Location: ______ Bureau, Institution, or District: ______
ACCIDENT	Date: ______ Time: ______ Location: ______ Type of Claim: Bodily Injury: ______ Property Damage: ______ Medical Malpractice: ______ Other: ______ Description: ______
INJURED PERSON	Name: ______ Age: ______ Telephone No.: ______ Address: ______ City: ______ State: ______ Occupation & Employer: ______ Why on Premises: ______ Nature & Extent of Injury: ______ (List additional injured persons on back of form.)
PROPERTY DAMAGE	Owner & Address: ______ Telephone No.: ______ Description of Property: ______ Describe Damage: ______ When & where can property be inspected: ______

DFS-D0-1403
Revised 11/05
Rule 69H-2.008

	Name	Address	Telephone No.
WITNESSES			

POLICE REPORT	Identify Police Authority Investigating: ______ Their Location: ______

(USE BACK FOR ADDITIONAL COMMENTS)

Date of Report	Signature of person filing report
	Telephone No.:

(List additional injured persons here.)

INJURED PERSON	Name: ______ Age: ______ Telephone No.: ______ Address: ______ City ______ State: ______ Occupation & Employer: ______ Why on Premises: ______ Nature & Extent of Injury: ______
INJURED PERSON	Name: ______ Age: ______ Telephone No.: ______ Address: ______ City ______ State: ______ Occupation & Employer: ______ Why on Premises: ______ Nature & Extent of Injury: ______
INJURED PERSON	Name: ______ Age: ______ Telephone No.: ______ Address: ______ City ______ State: ______ Occupation & Employer: ______ Why on Premises: ______ Nature & Extent of Injury: ______

ADDITIONAL COMMENTS:

DFS-D0-1403
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

Questions?

Thank You

For additional information, please contact:

TORT claims North of Orange County:

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North Tort Claims Unit
Division of Risk Management
Florida Dept. of Financial Services
(850)413-4874
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
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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
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Or visit our website at
http://www.fldfs.com/Division/Risk/

RISK MANAGEMENT
Loss Prevention and Claims Administration for State Agencies