

VEHICLE GLASS REPAIR / REPLACEMENT LOSS NOTICE

AGENCY'S NAME		COMPLETE IF DIFFERENT FROM AGENCY NAME VEHICLE OWNER'S NAME			
ADDRESS		ADDRESS			
CONTACT PERSON'S NAME		PHONE NUMBER			
DATE OF BREAKAGE	TIME AM PM	DATE REPORTED	WORK PHONE	HOME PHONE	
REPORTED TO		PHONE NUMBER	LOCATION OF VEHICLE		
LOCATION CODE	CHECK ONE <input type="checkbox"/> STATE VEHICLE <input type="checkbox"/> OTHER				

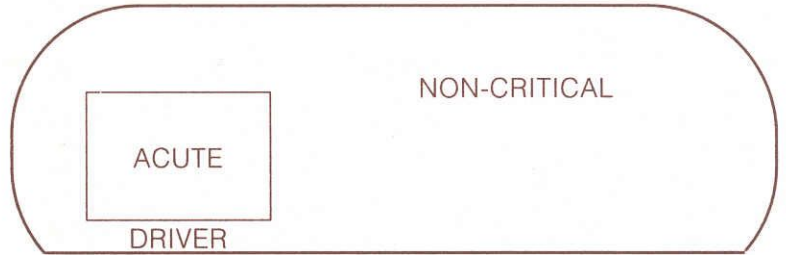
VEHICLE INFORMATION

YEAR	MAKE	MODEL	BODY STYLE	LIC. / EQUIPMENT NO.	VIN
DID BREAKAGE OCCUR DUE TO ACCIDENT	YES NO	MOTOR VEHICLE ACCIDENT REPORT ATTACHED	YES NO	GLASS DAMAGED REPLACEMENT	REPAIR
DESCRIBE HOW BREAKAGE OCCURED					

DAMAGED AREA INSPECTED BY	PHONE NUMBER	DATE
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IF WINDSHIELD, CHOOSE THE TYPE OF DAMAGE AND INDICATE LOCATION ON DIAGRAM

- 1. STAR BREAK 
- 2. BULL'S EYE 
- 3. HALFMOON 
- 4. CRACKED 
- 5. PITTED
- 6. SHATTERED



COMMENTS

SIGNATURE OF AGENCY REPRESENTATIVE	DATE
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For internal use only: 6410 State of Louisiana Glass-Auto

Email to 6410StateofLouisiana@sedgwickcms.com or fax to 855-563-2447