

**OFFICE OF MOTOR VEHICLES**  
P.O. BOX 64886, BATON ROUGE, LA 70896-4886  
1-225-925-6146 [www.expresslane.org](http://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
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**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 <input type="checkbox"/> MALE <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> 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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
VEHICLE (YEAR AND MAKE)	VEHICLE IDENTIFICATION NUMBER (VIN)	STATE	LICENSE PLATE NUMBER

**DAMAGE TO VEHICLE**

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

AMOUNT	DESCRIPTION	AMOUNT
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**INJURIES AND/OR DEATHS CAUSED BY THE ACCIDENT**

NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	<input type="checkbox"/> UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	<input type="checkbox"/> UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	<input type="checkbox"/> UNDER AGE 18
NAME	ADDRESS	CITY	STATE	ZIP	MEDICAL AMOUNT	<input type="checkbox"/> 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 <b>X</b>	SIGN NAME <b>X</b>
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