

**STATE OF OHIO
DEPARTMENT OF ADMINISTRATIVE SERVICES
OFFICE OF RISK MANAGEMENT**

Claim Number:
Agency:
Driver:

Accident Date:
Total Amount Due:
Your Driver:

Dear _____

We have received a report of an occurrence in which you were involved with a state owned vehicle. As a result, payment has been made in the amount listed above and we are now looking to you for reimbursement.

If you were covered by insurance, merely complete **Section 1** below and return this form to us. We will then deal directly with your insurance company. If you were not covered by insurance, please send us your check for the above amount. If this amount is such that you cannot pay it all at once, please complete **Section 2** below and return this form to us. Failure to pay, if liable, or to make arrangements for payment can result in the revocation of your driving rights by the Financial Responsibility Division of the State. (See **Section 3** and complete this).

Please return this completed form to us within TWO weeks.

Thank you,
OFFICE OF RISK MANAGEMENT
AUTO SUBROGATION

SECTION 1		
Your Insurance Company	Phone Number ()	Your Policy Number
(Street Number)	(City)	(State) (Zipcode)
SECTION 2 INSTALLMENT AND SETTLEMENT INFORMATION		
I wish to make a settlement on the installment basis YES <input type="checkbox"/> NO <input type="checkbox"/>		Date of Birth MONTH DATE YEAR <input type="text"/> <input type="text"/> <input type="text"/>
Your Full Name (Last) (First) (Middle)		
Social Security Number	Home Phone Number ()	Work Phone Number ()
Where do you work?		
Your work address (Street Number) (City) (State) (Zipcode)		
NOTE		
MINIMUM ACCEPTABLE MONTHLY PAYMENT IS \$ _____ per month	BEGINNING DATE:	MAKE CHECKS PAYABLE TO THE STATE OF OHIO
MAIL TO: STATE OF OHIO OFFICE OF RISK MANAGEMENT ATTN: AUTO CLAIMS 4200 SURFACE ROAD COLUMBUS, OH 43228-1395		SECTION 3 Have you complied with the requirements of the Financial Responsibility Law? YES <input type="checkbox"/> NO <input type="checkbox"/>

Signature: _____

Date: _____