OneMain Solutions

Underwritten by:
Triton Insurance Company
P.O. Box 2548, Fort Worth, Texas 76113-2548
Toll Free 800-307-0048 / Fax 800-350-9582
InsClaims@onemainfinancial.com

Insured's Name: _____ Account/Policy # _____ Claim # _____
(if available)

Collateral Protection Claim Form

Important Information

For Arizona residents only: "For your protection Arizona law requires the following statement to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

For California residents only: "For your protection California law requires the following to appear on the form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

If the loss is due to theft, the claim form must be signed in the presence of a branch representative OR a Notary Public.

Branch Representative's Signature _____

I swear that the information in the completed claim form is true to the best of my knowledge.

Signed before me, a Notary Public in _____ County on _____, _____ .

My commission expires on _____, _____ .

_____ _____
Signee/Affiant **Notary Public's Signature**

_____
Seal

For Pennsylvania residents only: "Any person who, with the intent to defraud, knowingly submits an application to or files a claim with an insurance company or other person containing false, incomplete, misleading or deceptive facts, statements or information may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that can include fines and confinement in prison."

For residents of other states (NOTE: None of these notices apply to Oregon residents.): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to civil and criminal penalties."

For New York residents only: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."**

SIGNATURE: _____ **DATE:** _____

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Collateral Protection Claim Form - Instructions

1. Read, complete, sign, and date all applicable portions of the Statement of Insured.
2. Send (a) a copy of the Policy and/or fire report of other documents verifying the incident causing the loss; (b) if applicable, theft and recovery reports.

   Note: Altered forms cannot be accepted.
3. If the vehicle is 5 years or older, send clear photographs of all damaged areas and 2 different repair estimates.
4. Send all pages of the completed, signed claim form and any attachments to the Insurance Claims Department shown above. Keep a copy for your records. Please be aware email is not considered a secure method of delivery for your personal information.

Statement of Insured - To be completed by Insured

Name **Telephone #**

Complete mailing address **City** **State** **Zip**

Email address (optional) **Driver's License #**

Vehicle year **Make** **Model** **Last 7 of VIN #**

Date of Loss ☐☐ / ☐☐ / ☐☐ **Were you at fault in the accident?** ☐ **YES** ☐ **NO**

Address where loss occurred

City **State** **Zip**

Is vehicle drivable? ☐ **YES** ☐ **NO** **State where vehicle is registered** _____

Address where vehicle is located **City** **State** **Zip**

Detailed statement of the circumstances surrounding the theft or loss

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(if available)

Statement of Insured - To be completed by Insured

Was the Police/Fire Department notified? ☐ **YES** ☐ **NO** **If Yes, Police/Fire Department report #** _____

Name of Police/Fire Department **City** **State** **Zip**

IF OTHER VEHICLE WAS INVOLVED,

Was the other vehicle insured? ☐ **YES** ☐ **NO**

If yes, are you making a claim against the other owner's insurance company? ☐ **YES** ☐ **NO**

Name and address of other owner's insurance company

City **State** **Zip**

Insurance Company telephone # **Policy #**

Name of owner of the other vehicle (First MI Last) **Telephone #**

Complete mailing address **City** **State** **Zip**

Name of driver of the other vehicle (First MI Last) **Telephone #**

Complete mailing address **City** **State** **Zip**

Name of witness to the accident (First MI Last) **Telephone #**

Complete mailing address **City** **State** **Zip**

I affirm the information I have provided herein is accurate and complete. Signature below is the Claimant or legal representative.

Signature _____ **Date** _____