Triton Insurance Company
P.O. Box 2548
Fort Worth, TX 76113-2548
Toll Free 800-307-0048 | Fax 800-350-9582 | insclaims@omf.com

Insured's Name: _____ **Claim Number:** _____

Account/Policy Number: _____

GAP Total Loss 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 this 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."

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 also 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** (mm/dd/yy) _____

For Pennsylvania residents only: "Any person who, with 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, with 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 or any insurance representative doing so to a policyholder or claimant with regard to a settlement or award payable from proceeds may be reported to the department of regulatory agencies and may be guilty of insurance fraud which is a crime and subjects such person to civil and criminal penalties that include fines and confinement in prison."

Usted puede obtener la versión en español de este formulario de reclamación en el sitio web de OneMain Solutions - www.onemainsolutions.com - Find a Form

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GAP Total Loss Claim Form - Instructions

1

❑ 1. Fully complete, sign, and date Insured's Section.

❑ 2. Attach a copy of the Vehicle Valuation report and Insurance Settlement Statement from the primary insurance company.

2

- Depending on your coverage requirements, additional documentation may be required.
- It is important to submit a fully completed, signed, and dated claim form and required documentation to avoid delays in processing your claim. Altered claim forms may not be accepted.
- Please be aware email is not considered a secure method of delivery for personal/medical information.

3

Please return your completed claim form and supporting documents to us in one of the following ways:

Email: insclaims@omf.com
Please be sure to include your name and account number/claim number in the subject line of your email.

Upload online:
www.OneMainSolutions.com/forms

Mail: OneMain Solutions
P.O. Box 2548
Fort Worth, TX 76113-2548

Fax: 800-350-9582

We are here to help!

Our Customer Solutions team is available to assist you
Monday through Friday, 8:00 am to 8:00 pm ET.

Toll free:
800-307-0048

Chat:
www.OneMainSolutions.com

Text:
60223

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Account/Policy Number: _____

GAP Total Loss Claim Form Insured's Section - To be completed by insured.	
Name	
Mailing address City State Zip	
Telephone number	Email address (optional)
Date of loss (mm/dd/yy)	Type of loss (Collision, Theft, Other)
Vehicle make	Vehicle model
Vehicle year	Last 7 of VIN number
Did an insurance company deem your vehicle a total loss? ❑ Yes ❑ No ❑ Not applicable	
Name of primary insurance company handling claim	
Adjuster's name	Adjuster's telephone number
Policyholder's name	Policy number
Claim number	Insurance company's telephone number
Mailing address City State Zip	
Email address (optional)	
I affirm the information I have provided herein is accurate and complete. **Signature** _____ **Date** (mm/dd/yy) _____	

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