INSURANCE VERIFICATION RESPONSE FORM (F/F MIC)

<table>
<thead>
<tr>
<th>CUSTOMER NAME (LAST, FIRST, M.I.)</th>
<th>DRIVER NUMBER</th>
<th>VEHICLE PLATE NUMBER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>VEHICLE IDENTIFICATION NUMBER (VIN)</th>
<th>INSURANCE COMPANY NAME (NOT AGENT)</th>
<th>POLICY NUMBER</th>
</tr>
</thead>
</table>

Vehicle Sold?

☐ YES* ☐ NO

(*If “Yes,” please complete boxes to the right)

Vehicle Registered Out-of-State?

☐ YES* ☐ NO

(*If “Yes,” please complete boxes to the right)

Provide specific details why vehicle was without liability coverage on date of notice:

SIGNATURE  

X  

DATE

DMV USE ONLY

DATE STAMP:  

TSR INITIALS: _________

FAX to: Accident Unit (503) 945-5267

or

Mail to: Insurance Verification Unit

DMV

1905 Lana Ave NE

Salem OR 97314

From: