OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

UNINSURED ACCIDENT REPORT

The owner or driver (or insurance company representative) of an insured vehicle that is involved in an accident with an uninsured vehicle may file this report with the Bureau of Motor Vehicles (BMV). In order to suspend the driving privileges of the uninsured party ALL of the following are required:

- The accident must have occurred in Ohio and this report must be received within six months of the date of the accident
- Vehicle damage must exceed $400 and an itemized estimate or bill included, or there must be personal injury exceeding $500
- A minimum of three identifiers (IDs) that match BMV records (name, address, date of birth, Ohio driver license number, social security number) are required for the party that is to be suspended.
- Either the license plate number or vehicle identification number (VIN) must be provided

ACCIDENT INFORMATION (MUST HAVE OCCURRED IN OHIO)				
ACCIDENT DATE	TIME	NUMBER OF VEHICLES INVOLVED	POLICE REPORT TAKEN? (IF YES, INCLUDE COPY) ☐ Yes ☐ No	
ADDRESS	CITY	STATE OH	ZIP CODE	

DRIVER TO BE SUSPENDED (MINIMUM OF 3 IDENTIFIERS REQUIRED THAT MATCH BMV RECORDS)				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE or VIN (Required)	STATE OF ISSUANCE	
DRIVER LICENSE NUMBER	STATE OF ISSUANCE	SSN	DOB	

OWNER OF VEHICLE TO BE SUSPENDED (MINIMUM OF 3 IDENTIFIERS REQUIRED THAT MATCH BMV RECORDS)				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE or VIN (Required)	STATE OF ISSUANCE	
DRIVER LICENSE NUMBER	STATE OF ISSUANCE	SSN	DOB	

DRIVER OF DAMAGED VEHICLE (IF APPLICABLE)				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE NUMBER	STATE OF ISSUANCE	
DRIVER LICENSE NUMBER	STATE OF ISSUANCE	SSN	DOB	

OWNER OF DAMAGED VEHICLE				
NAME		PHONE		
ADDRESS		CITY	STATE	ZIP
YEAR OF VEHICLE	MAKE OF VEHICLE	LICENSE PLATE NUMBER	STATE OF ISSUANCE	
DRIVER LICENSE NUMBER	STATE OF ISSUANCE	SSN	DOB	

DENIAL OF COVERAGE

IS THERE A DENIAL OF COVERAGE FOR THE DRIVER OR OWNER OF VEHICLE TO BE SUSPENDED? (IF YES, INCLUDE COPY) ☐ Yes ☐ No

INDIVIDUAL HANDLING THEIR OWN CLAIM

- IF YOU ARE HANDLING YOUR OWN CLAIM, PLEASE COMPLETE THE INFORMATION BELOW.
- YOU SHOULD NOT COMPLETE THIS FORM IF YOUR INSURANCE COMPANY IS HANDLING THE CLAIM.
- YOUR CONTACT INFORMATION WILL BE PROVIDED TO THE OTHER PARTY TO MAKE RESTITUTION.

NAME		PHONE	
ADDRESS	CITY	STATE	ZIP
INSURANCE COMPANY NAME	POLICY NUMBER	POLICY EFFECTIVE DATES	

INSURANCE COMPANY HANDLING THE CLAIM

- IF YOU ARE AN INSURANCE COMPANY OR ITS REPRESENTATIVE, PLEASE COMPLETE THE INFORMATION BELOW.

INSURANCE COMPANY	POLICY NUMBER	CLAIM NUMBER	
OFFICE HANDLING CLAIM	PHONE	FILE NUMBER	
ADDRESS	CITY	STATE	ZIP

VEHICLE DAMAGE INFORMATION (MUST INCLUDE ESTIMATE AND EXCEED $400)

DAMAGE AMOUNT

PERSONAL INJURY INFORMATION (MUST INCLUDE DOCUMENTATION AND EXCEED $500)

INJURED NAME		PHONE	
ADDRESS		CITY	STATE / ZIP
SSN	DOB	☐ Driver	☐ Passenger

AMOUNT OF CLAIM

SIGNATURE OF PERSON COMPLETING FORM (REQUIRED)

PRINTED NAME

I certify the information in the report to my knowledge is accurate, and that the damaged vehicle is covered by liability or another form of acceptable proof of financial responsibility as required by Ohio Revised Code 4509.101

SIGNATURE	DATE
X	

COMPLETED REPORT MAY BE SENT

By Mail: OHIO BUREAU OF MOTOR VEHICLES
ATTN: COMPLIANCE UNIT
P.O. BOX 16583
COLUMBUS, OH 43216-6583

By Fax: (614) 308-5107

By E-Mail: BMV3303@dps.ohio.gov

You will receive notification by mail regarding status of request and/or individuals insurance information if provided to the BMV.