January 28, 2021

Responsible Party First and Last Name

Responsible Party Mailing Address

Responsible Party City, State Zip Code

RE: ***CITY OF RESTITUTION DEMAND SECOND REQUEST***

DATE OF LOSS: Month/Day/Year

 LOSS LOCATION: Specific Address

 DAMAGES: What was damaged

 CITY FILE NUMBER: City File Number

Dear Mr., Mrs., or Ms. Responsible Party Last Name:

Please be advised that the CITY NAME sustained damage to a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The damages are the result of a collision due to the negligent operation of your motor vehicle. The CITY NAME sustained $\_\_\_\_\_\_\_ in damages.

We have previously attempted to contact you and to date, have not received a response. A copy of the City’s Repair Costs, Traffic Collision Report and Photographs of the damages, are again enclosed for your review. If you have insurance, please forward this letter immediately to your insurance company, and return the enclosed form. If you do not have insurance to pay this claim, please contact the undersigned immediately so that we can discuss a resolution of this matter.

If you fail to respond within the next 30 days, we will be forced to take further action, which could include, a legal action and resulting judgment against you. Unpaid damages can result in the loss of your motor vehicle license plate, ADD LICENSE PLATE NUMBER, as well as suspension of your drivers’ license.

Please contact the undersigned should you have any questions. Thank you for your cooperation and courtesy.

Respectfully,

Name

Title

Enclosure

Cc: City Officer, City Officer’s Title, Name of City (without enclosure)

Responsible Party First and Last Name

Claim Number

Your Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of your insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The name on the policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your agent’s name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you reported this loss to your insurance company?

Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

If yes, what claim number has your insurance company assigned to the claim

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am willing to make payments to the City in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on a

monthly basis until my debt is satisfied.

Please return this form to: CITY

 Address

 City, CA

Thank you for your cooperation.