MASIT
MAS Insurance Trust

793 North President Street | Jackson, Mississippi 39202
(601) 353-2741 Ph | (601) 353-2749 Fx

MASIT Employee Directory

Name	E-mail	Extension
Leslie Scott, Administrator	lscott@massup.org	202
Renada Skannal, Service Manager	rskannal@massup.org	209
Derrick Surrette, Treasurer	dsurrette@massup.org	204
Brooks Miller, Risk Mgmt Specialist	bmiller@massup.org	211
Donna Hopkins, Bookkeeper	dhopkins@massup.org	201

How to File a Claim

Complete Claim Reporting form and return to your agent or CCMSI

Address

P.O. Box 1378
Ridgeland, MS 39158

Phone

Toll Free	(800) 672-1108
Local	(601) 899-0148
Fax	(601) 899-0160

Email

msnewclaims@ccmsi.com

John Burns
State Director
jburns@ccmsi.com

Lisa Wells
Claims Supervisor
lwells@ccmsi.com

Amanda Rayburn
Claims Adjuster
arayburn@ccmsi.com

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Please return this form to:
msnewclaims@ccmsi.com
or Fax to: (601) 899-0160

CLAIM REPORTING FORM

County: _____ Department: _____
Address: _____ City/St/Zip: _____
Contact Person: _____ Phone No.: _____

OTHER THAN AUTO ACCIDENT

Name: _____ Social Security No.: _____ - _____ - _____
Home Address: _____ City/St/Zip: _____
Home Phone: (_____) _____ - _____ Alt Phone: (_____) _____ - _____
Date of Loss: _____/_____/_____ Time of Loss: ____:____ am/pm Location of Accident: _____
Description of Accident: _____
_____
_____

AUTO ACCIDENT Involving ☐ County owned ☐ Non-County owned

Name of County Driver: _____ Social Security No.: _____
Home Address: _____ City/St/Zip: _____
Home Phone: (_____) _____ - _____ Alt Phone: (_____) _____ - _____
Date of Loss: _____/_____/_____ Time of Loss: ____:____ am/pm County Vehicle Tag No.: _____
Description of County Vehicle Involved: Year _____ Make _____ Model _____ Color _____
Description of 2nd Vehicle: ☐ Cty ☐ Other Year _____ Make _____ Model _____ Color _____
Description of Accident/Damages: _____
_____
_____

PROPERTY DAMAGE (Not Auto Related)

Description of Property: _____ Description of Damage: _____
Owner's Name: _____ Phone: (_____) _____ - _____
Home Address: _____ City/St/Zip: _____
Location of Property (for inspection): _____

INJURY (Non-County Employees)

Name: _____ Name: _____
Home Address: _____ Home Address: _____
City/St/Zip: _____ City/St/Zip: _____
Description of Injury: _____ Description of Injury: _____
Injured person taken to doctor/hospital? ☐ Yes ☐ No Injured person taken to doctor/hospital? ☐ Yes ☐ No
If yes, where?: _____ If yes, where?: _____
Name: _____ Name: _____
Home Address: _____ Home Address: _____
City/St/Zip: _____ City/St/Zip: _____
Description of Injury: _____ Description of Injury: _____
Injured person taken to doctor/hospital? ☐ Yes ☐ No Injured person taken to doctor/hospital? ☐ Yes ☐ No
If yes, where?: _____ If yes, where?: _____

WITNESS OR PASSENGER

Name: _____
Home Address: _____ City/St/Zip: _____
Phone: (_____) _____ - _____ Alt Phone: (_____) _____ - _____

Person completing this form: _____ Date Completed: _____

Contact CCMSI Toll Free at (800) 672-1108 or locally at (601) 899-0148
Lisa Wells: lwells@ccmsi.com Amanda Rayburn: arayburn@ccmsi.com