ACCIDENT REPORT **INSURED STATEMENT** **You Must Answer All Questions**

DESCRIPTION OF YOUR CAR CLAIM NO: _____

Make _____ Year_____Body Type_____Lic. Plate/State_____

Owner_____Date of Birth_____Married? Y N

Address_____Floor/Apt#_____City_____State__Zip_____

Phone (Home)_____(Work)_____(Cell)_____

Driver's License No._____State___ E Mail_____

Driver _____Date of Birth_____Married? Y N

Address_____Floor/Apt#_____City_____State__Zip_____

Phone (Home)_____(Work)_____(Cell)_____

Driver's License No._____State ____ E Mail_____

For what purpose was car being used at time of accident_____

Describe damages to your car_____

Drivers Relationship To Owner_____Is damage over $500? Y N Is Car Drivable? Y N

If car is not drivable, where can car be seen_____

List dates of prior accidents_____

Describe any prior damage to your vehicle:_____

Including the driver, how many occupants were in your car_____

DESCRIPTION OF OTHER CAR

Make _____ Year_____Body Type_____Lic. Plate/State_____

Owner_____Date of Birth_____Married? Y N

Address_____Floor/Apt#_____City_____State__Zip_____

Phone (Home)_____(Work)_____(Cell)_____

Driver _____Date of Birth_____Married? Y N

Address_____ City_____State_____Zip_____

Driver's License No._____State ____ E Mail_____

Describe damages to other car_____

Insurance company, claim or policy number_____ Number Occupants (Inc. Driver)_____

TIME, PLACE AND FACTS OF LOSS

Date of accident_____Year_____Time_____ AM PM Daylight or Dark?_____

Location_____City_____State_____

Type of road_____Wet or Dry_____Weather_____

Your direction_____On what street_____

Their direction_____ On what street_____

Did you have a stop sign, traffic control or traffic light_____Other Party_____

Did you fail to observe stop sign or traffic light_____Other Party_____

Were you ticketed for any traffic violations_____Other Party_____

What violations?_____

Did you admit blame for accident?_____Other Party_____

Was accident reported to police? Y N Which police dept. (City or Town)_____

Police Report No._____Desk Report or On Scene_____

****** Be Sure To Complete And Sign The Other Side Of This Form ******

ALL OTHER WITNESSESS

List all witnesses to the accident who were not passengers in either car:

Name Age Address Phone No.

_____

_____

_____

BODILY INJURY

Was anyone injured (please state yes or no)_____If yes, give name, date of birth, sex and address of all persons injured in the accident:

Name DOB Address Type of Injury In Which Vehicle

_____

_____

_____

Hospital Taken To_____

Doctor_____Address_____

OTHER INSURANCE

Do you have coverage for Collision – Liability – Health Insurance – Doctor's Bills?

If so, list the companies and coverages:_____

Policy or Claim #_____

ATTACH ANOTHER SHEET OF PAPER IF MORE SPACE IS NEEDED

IMPORTANT

Describe in your own words how the accident happened:

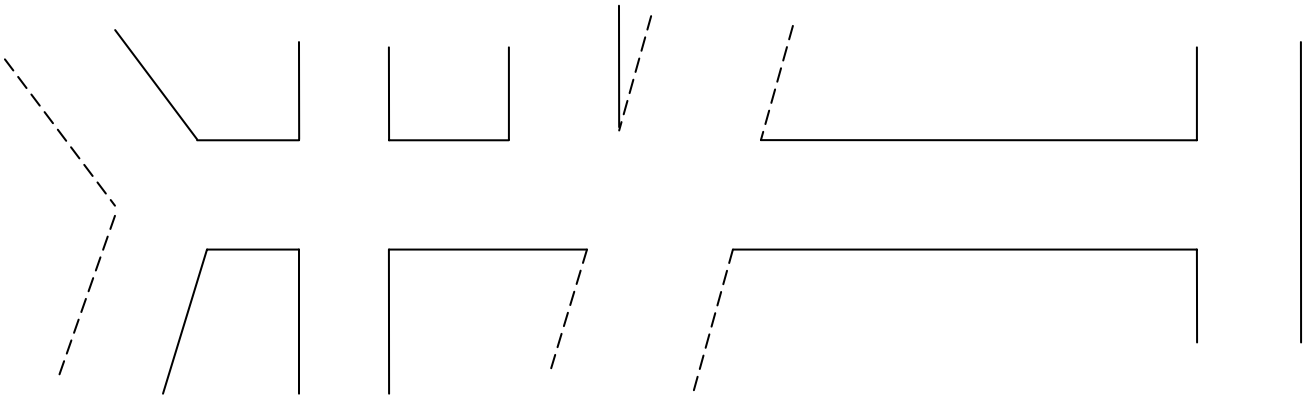
_____

_____

_____

_____

Please show on diagram the names of streets, directions and locations of objects concerned, and TRAFFICE SIGNS and STOP SIGNS. Mark your car "A", other car "B", showing the points of impact and where vehicles stopped after collision. Include any helpful information. Indicate NORTH by arrow.



Signature_____ Date_____