

# AUTOMOBILE ACCIDENT REPORT

Claim number

|   |      |  |                        |  |                                    |                    |
|---|------|--|------------------------|--|------------------------------------|--------------------|
| Worker's Surname  |      | First name                               |                        | Initial  | Date of birth (Year / Month / Day) |                    |
| Home address Street   |      | City/Town                                |                        | Province   |                                    | Postal code        |
| Phone number  |      | Your insurance company and policy number |                        |  |                                    |                    |
| Business address Street   |      | City/Town                                |                        | Province   |                                    | Postal code        |
| Phone number  |      |  |                        |  |                                    |                    |
| Make of vehicle   | Year | Model                                    | Serial number          | License number and province  |                                    |                    |
| Describe damage   |      |  |                        |  |                                    | Estimate of damage |
| Name of driver of your vehicle  |      |  | Age                    | Driver's license number  |                                    |                    |
| Residence address Street  |      | City/Town                                |                        | Province   |                                    | Postal code        |
| Business phone number   |      |  |                        |  |                                    |                    |
| Date of accident (Year / Month / Day)   |      | Time                                     |                        | Were you wearing a seat belt?  |                                    |                    |
|   |      |  |                        | <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> Yes <input type="checkbox"/> No |                                    |                    |
| Location of accident  |      |  |                        |  |                                    |                    |
| Purpose vehicle used for at time of accident  |      |  | Weather condition      |  | Road condition                     |                    |
| Your speed  |      | Direction                                |                        | Other's speed  |                                    | Direction          |
| Police investigation by   |      |  |                        |  | Charges                            |                    |
| Had you taken any alcoholic beverages or drugs prior to the accident <input type="checkbox"/> Yes <input type="checkbox"/> No |      |  |                        |  |                                    |                    |
| Who was responsible for the accident - reason   |      |  |                        |  |                                    |                    |
| Owner of other vehicle  |      |  | Owner of other vehicle |  |                                    |                    |
| Phone number  |      |  | Phone number           |  |                                    |                    |
| Address   |      |  | Address                |  |                                    |                    |
| Make of vehicle   |      | Year                                     |                        | Make of vehicle  |                                    | Year               |
| Model   |      | License number and province              |                        |  | Model                              |                    |
|   |      |  |                        |  | License number and province        |                    |
| Name of insurance company   |      |  | Policy number          |  | Name of insurance company          |                    |
|   |      |  |                        |  | Policy number                      |                    |
| Description of damage   |      |  | Description of damage  |  |                                    |                    |
| Name of driver  |      |  | Phone number           |  | Name of driver                     |                    |
|   |      |  |                        |  | Phone number                       |                    |
| Address   |      |  | Address                |  |                                    |                    |



