

SENTRY

(WEST INDIAN INSURANCES LIMITED)

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KINGSTOWN, ST. VINCENT

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MOTOR ACCIDENT REPORT FORM

POLICY HOLDER'S NAME: _____

ADDRESS: _____

TRADE OR OCCUPATION: _____

CLAIM No. _____

POLICY No. _____

PERIOD: _____

PRIVATE TELEPHONE No. _____

BUSINESS TELEPHONE No. _____

Do you hold more than one policy indemnifying you in respect of this occurrence? _____

PARTICULARS OF VEHICLE

Make & Model _____ Engine Size. _____ Year _____ Reg. No _____

For what purpose was it being used at the time of the accident? _____

Is the vehicle owned by you? _____ If not, please state the Owner _____

How many of your vehicles were in use at the time of the accident? _____

If used for carriage of goods, state whether for own trade delivery _____

Give particulars of nature and weight of the goods carried _____

If used for passenger hire, state how the vehicle was so hired _____

DRIVER

Name and address of driver at the time of accident _____

Date of Birth _____ Driver's Licence No. _____ Date of Issue _____

State Class or Classes of Vehicle licence permits holder to drive _____

Give details of all prosecutions in connection with the driving of a motor vehicle _____

Is he a paid driver in your service? _____ . How long has he been in your employment? _____

Was he acting within the scope of his authority? _____

Give all details of driver's previous accident? _____

If a relative or friend is driving, does he/she own a car? _____

If so, name his/her Insurance Company _____

WITNESSES - Give Names and Address of :-

PASSENGERS (if any)	OTHER WITNESSES
State whether carried for hire or reward	

Did a Police witness the accident, or TAKE PARTICULARS? _____

If so, give Number, Name and Station _____

PERSONAL INJURY, DAMAGE TO OTHER PERSONS' VEHICLE or PROPERTY

Name and Address of Owner of other vehicle _____

Name and Address of Driver of Other Vehicle _____

Reg. No. of Other Vehicle involved _____ Damage to other vehicle _____

Name and Address of injured person(s) _____

Nature of injuries sustained _____

To what hospital, if any was/were the injured person(s) taken? _____

Damage to Property _____

Name and Address of Owner of any damaged Property _____

Has any claim been made to you? _____ . If so, verbally or in writing? _____

Please forward at once any related communication you may have received unanswered.

DAMAGE TO POLICYHOLDERS'S VEHICLE

Have you obtained an Estimate for Repairs? _____
If so, from whom? _____ Address _____
Amount of Estimate _____ (please forward it in writing)
Where can your Vehicle be inspected? _____

CIRCUMSTANCES OF ACCIDENTS

Date of accident? _____ Time of Accident? _____ a.m/p.m
Place where accident occurred _____
Was your vehicle on the left side of the road? _____ (a)If not, what part of the road was it? _____

(b)If so, how far from the kerb? _____
Was the road wet or dry? _____ Did you /your driver give any warning and how? _____
Did the driver of the other vehicle (if any) give any warning and how? _____
If the accident occurred after the lighting up time was: (a) your vehicle lighted and how? _____

(b) the other vehicle lighted and how? _____
What was the speed of your vehicle; (a) immediately before the impact? _____

(b) at the moment of impact? _____
In your opinion, who was to be blamed for the accident? _____

Give a full description of exactly how the accident occurred.

Please make a rough sketch (stating approximate measurements) showing position of vehicles and persons concerned and the direction in which they were travelling.

I/We hereby declare the foregoing particulars and statements to be true in every respect

DRIVER'S SIGNATURE: _____

DATE: _____

POLICYHOLDER'S SIGNATURE: _____

DATE: _____