LITTLE SONS

INSURANCE SERVICES

Auto Accident Report Form

Keep In Your Glove Box

POLICY HOLDER

Name:_____ Policy No:_____

Address:_____ Business Phone No:-_____

INSURED VEHICLE, DRIVER AND USE

Tractor-Bus: Year_____Make:_____Serial No:_____ Lic. No:_____Prov.:_____

Trailer- Bus: Year_____Make:_____Serial No:_____ Lic. No:_____Prov.:_____

Owner of Above Tractor:_____ Trailer:_____

Was equipment being operated about business of Assured:_____ Other Insurance Available:_____

Name of Driver:_____ _____

Address:_____ Phone No:_____

_____ Age:_____

Driver's Licence No:_____ No. of Hours on Duty:_____

CARGO LOSS

Type of loss and commodity:_____ Bill of Lading Enclosed:

PresentLocation:_____ No_____ Yes_____

DETAILS OF ACCIDENT

Date:_____ 19_____Time:_____am/pm_____ WeatherConditions_____

Place:_____ Conditions of Road:_____

Police Report Made To:_____City - Officers Number_____ City orTown:_____

Any Charges Laid:_____ Province:_____

What Charge:_____ AgainstWhom:_____

DAMAGE TO VEHICLE OF POLICY HOLDER

COLLISION:_____FIRE:_____THEFT:_____ OTHER: _____

Present Location of Assured'sVehicle?_____ Truck:_____Tractor:_____

Assureds Estimate of Damage: _____ Trailer:_____Bus:_____

Can Assured Complete Repairs?_____Were Temporary Repairs Made:_____ Amount:_____

DAMAGE TO PROPERTY OF OTHERS

Owner of Vehicle:_____ Driver of Vehicle:_____

Address:_____ Year and Make of Vehicle:_____

Licence No:_____Phone_____ Licence No:_____

Damage:_____ Policy No:_____

Insurance Company:_____ Province:_____

Owner of Vehicle:_____ Driver of Vehicle:_____

Address:_____ Year and Make of Vehicle:_____

Licence No:_____Phone_____ Licence No:_____

Damage:_____ Policy No:_____

Insurance Company:_____ Province:_____

INJURED

(1)	(2)	(3)
Name:_____	Name:_____	Name:_____
Address:_____	Address:_____	Address:_____
_____	_____	_____
Phone:_____Age:_____	Phone:_____Age:_____	Phone:_____Age:_____
Injuries:_____	Injuries:_____	Injuries:_____
Doctor:_____	Doctor:_____	Doctor:_____
Hospital:_____	Hospital:_____	Hospital:_____

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INSURANCE SERVICES

OCCUPANTS OF INSURED VEHICLE

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

OCCUPANTS OF OTHER VEHICLE:

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

IMPORTANT: INDEPENDENT WITNESSES: (Include names of bystanders who saw accident, or heard any statements made)

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

NAME:_____ **ADDRESS:**_____ **PHONE:**_____

THE ACCIDENT	**POLICYHOLDER'S VEHICLE:** **SPEED:** **Before The Accident:**_____**km/h** **At Instant of Accident:**_____**per hour** **LIGHTS:**_____ **(ON - OFF - DIM - BRIGHT)** **Which Side of Road**_____**Warning:**_____ **Direction Travelled:**_____	**OTHER VEHICLE:** **SPEED:** **Before The Accident:**_____**km/h** **At Instant of Accident:**_____**per hour** **LIGHTS:**_____ **(ON - OFF - DIM - BRIGHT)** **Which Side of Road**_____**Warning:**_____ **Direction Travelled:**_____

DRIVER'S STATEMENT OF HOW ACCIDENT OCCURRED:

What part of your vehicle and what part of other car were first in touch?_____

Whom do you consider is responsible?_____

Date Signed:_____Signature of Driver:_____

Date Reported:_____ How Reported:_____Phone:_____Wire:_____Letter:_____In Person:_____Time:_____

Attach a diagram to further explain accident, show points of compass, name of streets, direction of cars and position of cars at instant of accident