



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			



