



Tatil

... where people are people

Trinidad and Tobago Insurance Limited

TATIL Building, 11A Maraval Road, Port of Spain, Trinidad and Tobago, W.I.
Tel.: (868) 62TATIL(628-2845) • Web: www.tatil.co.tt • E-mail: info@tatil.co.tt

MOTOR VEHICLE ACCIDENT REPORT FORM

(Please give complete answers to all questions)

FOR OFFICIAL USE ONLY

Producer Name:

Branch:

Claim Number:

Adjuster Name:

THE INSURED

Name:..... Email Address:

Postal Address: Telephone:

Business Address: Telephone:

Occupation:

Are you VAT registered? Yes No State VAT Registration Number:

THE POLICY

Policy Number: Effective Date: Expiry Date:

Type of Coverage: Comprehensive Fire & Theft Third Party Crash Cash Courtesy Cash

If "NOT" Tatil, with whom is it insured?

Registration No.	Make and Model of Vehicle	Year	Chassis No. & Engine No.	Sum Insured

Is the vehicle registered in your name? Yes No If "No", in whose name?

Is the vehicle subject to any finance agreement? Yes No If "Yes", give details?

THE DRIVER

Name: Sex:

Postal Address: Telephone:

Business Address: Telephone:

Occupation:..... Employer:

Date of Birth	Age	Permit Number	Class	Date of Issue	Date of Expiry

Has Driver been previously involved in an accident? If "Yes", give details:

Has Driver been previously involved in a Traffic Offence? If "Yes", give details:

Driver's relation to the Insured: If employee, how long employed?

Does Driver own a Motor Car?..... Registration Number:

Where is it insured? Policy/Certificate Number:

THE ACCIDENT/THE THEFT

Date: Time: AM / PM Place:

For what purpose was the vehicle being used? Please describe fully:

Direction of Travel: Insured's Vehicle: Third Party's Vehicle:

Speed at time of accident:..... Condition of Road:

Was horn sounded?..... Was visibility good?

Police Station reported to: Name and Number of Police Officer:

Date and Time reported:

THE THIRD PARTY

	VEHICLE 1	VEHICLE 2
Vehicle Registration Number:		
Make and Model of Vehicle:		
Colour of Vehicle:		
Owner's Name:		
Owner's Address:		
Driver's Name:		
Driver's Address:		
Driver's Contact Number:		
Insurance Company:		
Policy and Certificate Number:		
Description of Damages and Your Estimate of the Cost of Repairs:		

DAMAGES TO INSURED'S VEHICLE

Description of Damages:

Name of Repairer: Was Estimate Prepared? Cost (\$):

Where can the vehicle be inspected?

PASSENGERS IN YOUR VEHICLE

Name	Age	Address	Details of Injury Sustained (if any)	Physician or Hospital

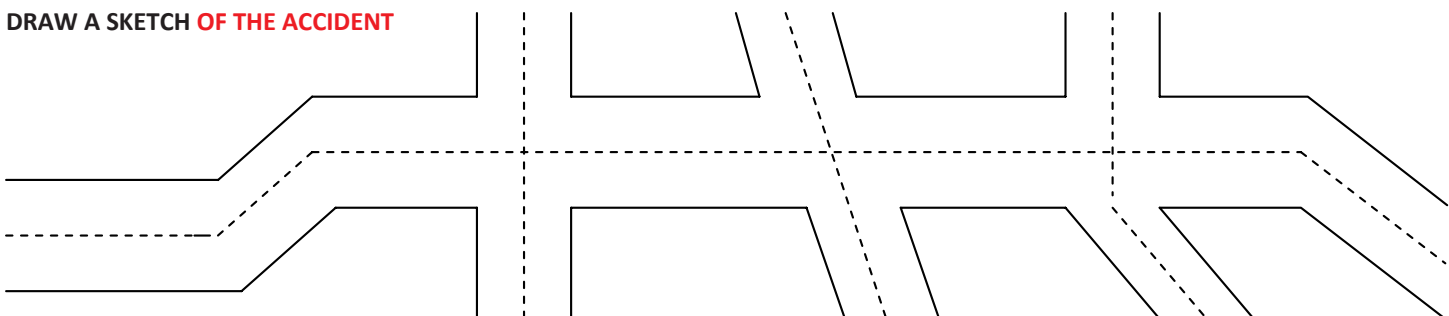
PASSENGERS IN OTHER VEHICLE/PEDESTRIANS

Name	Age	Address	Details of Injury Sustained (if any)	Physician or Hospital

INDEPENDENT WITNESSES

Name	Age	Address	Details of Witness (if any)	Telephone

DRAW A SKETCH OF THE ACCIDENT



GIVE FULL DETAILS OF THE ACCIDENT

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.....

In your opinion who was at fault? Did such person admit responsibility?

DECLARATION

Please confirm by selecting this box your declaration as follows:

- I/We declare that the above statements and facts are true and that I/We have not withheld any information within My/Our knowledge connected with the claim.

Signature of Insured: Date:

Signature of Driver: Date:

THE COMPANY DOES NOT ADMIT ANY LIABILITY BY THE USE OF THIS FORM.