Trinidad and Tobago Insurance Limited
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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

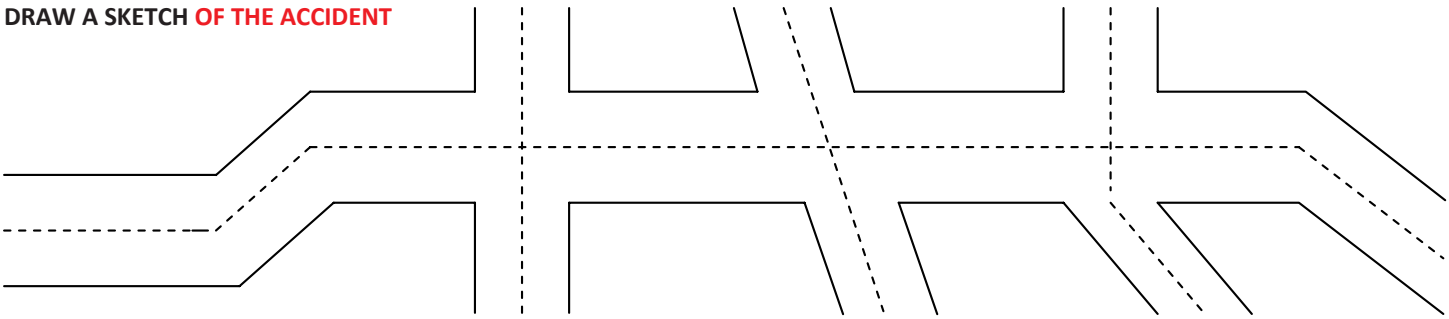
PASSENGERS IN OTHER VEHICLE/PEDESTRIANS

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.