STATE INSURANCE
COMPANY LIMITED

Live in a better State of mind

Redcliffe Street P.O. Box 290 St. John's Antigua. W.I.
(268) 481-7800/1/2/3/4 • info@sicantigua.com • sicantigua.com

MOTOR ACCIDENT REPORT FORM

(Please answer each question fully)

INSURED

Name of Insured ……..... Claim No……..…….....

Address……..... Policy No.....

Occupation ……..... Period: From ……..... To…….....

Tel. No. Work ……..…….....Home…….....

DRIVER

Name of Driver……..……..... Age.....

Address..... Tel.....

Relation to Insured : Employee Family Friend .....

Was vehicle used with owner's permission? .....

Driving Licence Particulars:-

Licence Number	Date first Issued	last Renewal Date	Was it Ever Endorsed or suspended	Type or classes of Vehicles permitted to drive

For what purpose was the vehicle being used? .....

Does the driver own a motor vehicle? .....

If so, name of Insurance Company .....

Policy No……..... Policy Period: From …….. To……..

Upon whose authority was the driver operating the vehicle? .....

To the best of your knowledge did the driver consume any intoxicating beverage or substance? .....

Prior to accident .....

INSURED VEHICLE

Reg . No	H.P or C.C	Make	Year	Chassis & Engine No.	Sum Insured	Any physical modification or alteration since submission of last proposal form

Policy Excess …….....

ACCIDENT

Date of accident …….. 20 ……..... Hour …….....a.m./p.m.

Accident Location ……..... .....

Direction Insured's Car ……..... other car.…….....

Speed at time of accident……..……..... weather conditions ……..…….....

Were particular taken by Police Officer? ……..…….....

If so, name ……..... Address of Police Station .....

DAMAGE TO INSURED VEHICLE

Parts damaged and extent.....

.....

.....

Where may the vehicle be seen .....

Have you authorized repairs or an estimate to be prepared? .....

Name of Garage……..……..... Tel No.…….....

PARTICULARS OF OTHER VEHICLE/S

REG. No	Make	Year	Damage

Is this vehicle under Hire Purchase Agreement ?.....

If so, state name of Finance Company ……..... Amt. $.....

PARTICULARS OF T.P. OWNER/ DRIVER

Name	Address	Name	Address

DETAILS OF INJURY/IES, IF ANY

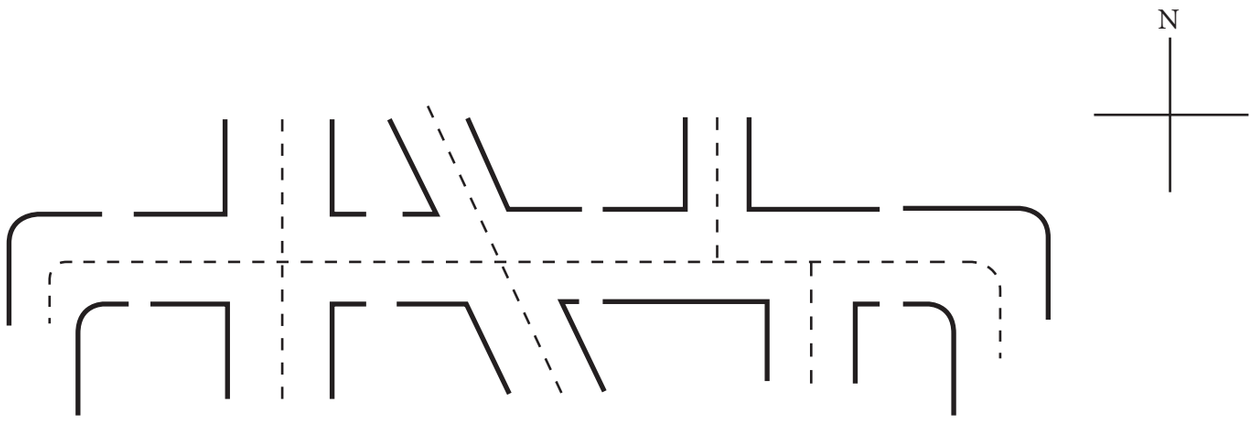
Name	Age	Nature of Injury

WITNESSES

Name..... Address.....
Name..... Address.....
Name..... Address.....

DESCRIPTION OF ACCIDENT THEFT FIRE

Complete the following diagram showing direction & positions of automobiles or property involved, designating clearly point of contact



NOTE

any notice, communication, writ or summons received by you from a lawyer must immediately be handed over to the company at the above address

I / We declare the foregoing particulars given are true in every respect

……..... .....
Signature of Driver Signature of Insured
Other than insured

Date of Report …….....