



# KEY INSURANCE COMPANY LIMITED

KEY-CL-22

6C Half Way Tree Road, Kingston 5, Jamaica WI

Telephone: 876-926-6278, 876-929-7940-3

Web: www.keyinsurancejm.com | Email: info@keyinsuranceja.com

CLAIM NUMBER \_\_\_\_\_

Date: \_\_\_\_\_

## MOTOR ACCIDENT REPORT FORM

### PARTICULARS OF THE INSURED

Name:	Alias:
Home Address:	
Occupation:	Employer/Business Name:
Employer/Business Address:	
Contact Numbers:	Email Address:

### PARTICULARS OF THE VEHICLE

Policy Number:	License Number:	Year:
Make:	Model/Type:	Colour:
Name and Address of any person or Company with a monetary interest in the vehicle:		
Was there any un-repaired damage prior to the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		
If <b>yes</b> , give details:		
Where on the vehicle was damaged in this accident?:		

### PARTICULARS OF USE

State fully the purpose for which the vehicle was being used at the time of the accident:		
Were goods being carried: Yes <input type="checkbox"/> No <input type="checkbox"/>	If <b>yes</b> , state the nature:	and weight (lb):
How many persons including the driver were in the vehicle?	Were they charged a fee to be transported? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was the vehicle driven by a person other than the insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If <b>yes</b> , by whose authority?		

### PARTICULARS OF ACCIDENT

Date of Accident:	Time:	Your approximate speed at time of accident (km):	
Location of Accident:		Who do you think was at fault:	
Was the accident reported to the police? Yes <input type="checkbox"/> No <input type="checkbox"/>		If <b>yes</b> , state name of policeman:	
Badge #:	Name of Police Station:	Were you warned for prosecution? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was the other driver warned for prosecution? Yes <input type="checkbox"/> No <input type="checkbox"/>		Was the pavement wet? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did the police visit the scene? Yes <input type="checkbox"/> No <input type="checkbox"/>		Were you wearing a seatbelt? Yes <input type="checkbox"/> No <input type="checkbox"/>	
How was the visibility? Dark <input type="checkbox"/> Well Lit <input type="checkbox"/>		Did you offer the Third Party compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Were there any independent witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/>		If <b>yes</b> , give information below:	
Witness #1 Name:		Witness #1 Contact #:	
Witness #2 Name:		Witness #2 Contact #:	
Did the driver of the other vehicle sign a written admission of liability? Yes <input type="checkbox"/> No <input type="checkbox"/> If <b>yes</b> , please attach.			
	<b>Insured's Vehicle</b>	<b>Third Party #1</b>	<b>Third Party #2</b>
Direction of Travel?			
On which side of the road?			
Head Lights (on, off, dim, bright)?			
Was indicator on or off?			
Was horn sounded?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

### PARTICULARS OF DAMAGE TO OWN VEHICLE

Was the vehicle damaged? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please state the following:	
Describe the damage:	
Did a wrecker remove your vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	If <b>yes</b> , give name:
Approximate cost of repairs: J\$	Current location of vehicle:
Name and address of repairers:	

### PARTICULARS OF PASSENGERS IN INSURED'S VEHICLE

1.	Name:	Occupation:
	Address:	Relationship to the insured/driver:
	Hospital attended:	Was passenger wearing seatbelt: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Nature of injuries, if any:	



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2.	Name:	Occupation:
	Address:	Relationship to the insured/driver:
	Hospital attended:	Was passenger wearing seatbelt: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Nature of injuries, if any:	
3.	Name:	Occupation:
	Address:	Relationship to the insured/driver:
	Hospital attended:	Was passenger wearing seatbelt: Yes <input type="checkbox"/> No <input type="checkbox"/>
	Nature of injuries, if any:	

## PARTICULARS OF THIRD PARTIES

<b>Was any pedestrian or cyclist injured?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please state the following:			
Name:		Contact Number:	
Address:			
Nature of injury, if any:			
Damage to cycle:		Hospital attended:	
<b>Third Party #1</b>			
a. Owner's Name:		Contact Number:	
Address:			
b. Driver's Name:		Contact Number:	
Address:			
c. Year:	Make:	Model:	Registration No.:
d. How many passengers were in the vehicle:		How many were injured:	
Nature of injuries:			
e. Nature of damage to vehicle:			
f. Insurance Company:			
<b>Third Party #2</b>			
g. Owner's Name:		Contact Number:	
Address:			
h. Driver's Name:		Contact Number:	
Address:			
i. Year:	Make:	Model:	Registration No.:
j. How many passengers were in the vehicle:		How many were injured:	
Nature of injuries:			
k. Nature of damage to vehicle:			
l. Insurance Company:			
<b>Was there damage to any other property (such as walls, fences, cultivations, animals)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give info below:			
<b>Property Owner #1</b>			
Name:		Contact Number:	
Address:			
Details:			
<b>Property Owner #2</b>			
Name:		Contact Number:	
Address:			
Details:			

## PARTICULARS OF THE DRIVER OF INSURED'S VEHICLE

Driver's Name:		Date of Birth:	
Driver's Address:			
Occupation:			
Contact Numbers	Cell:	Home:	Business:
Driver's License #:	Date Issued:	Collectorate:	
Type of License:	Classes of vehicles specified in license:		
Has it been endorsed? Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, give details:	





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## SKETCH AND MEASUREMENTS

Please state measurements in feet. Show approximate width of road.  
1 chain = 66 yards or 198 feet.

