GULF INSURANCE LIMITED
1 Gray Street, St Clair, Port of Spain, Trinidad. P.O. Box 489
Tel: 868-622-5878 or 868-822-6000 Fax: 868-628-0272/2167
Website: http://www.gulfinsuranceltd.com e-mail: info@gulfinsuranceltd.com

MOTOR ACCIDENT REPORT

THE ISSUE OF **THIS** FORM IS **NOT AN** ADMISSION OF A CLAIM

THE INSURED

POLICY NO: CLAIM NO:

NAME: AGENCY:

Email Address:

Occupation: EMPLOYER:

Phone: Business: Residential:

Address:
Res:
Bus:

THE AUTOMOBILE

Registration Mark	Make	Type of Body	Horse Power or CC	Year of Manufacture	Seating Capacity including Driver	Sum Insured

Is the automobile subject to a hire Purchase Agreement? If so, state the name of Finance Company:

THE DRIVER

NAME OF DRIVER: Driver's Permit No: Driving Experience yrs

CLASS: EXPIRY DATE:

Age: Address:

Occupation: Employer:

Employer's Address: Phone: Res

Has driver any physical impairment? Bus

Has driver been involved in any accident within the past three years? If so, explain on the reverse

Does the driver carry any form of automobile insurance?

Does the driver and his or her spouse own a motor vehicle?

(If so, give particulars and name of insurer)

For what purpose was the automobile being used? (indicate pleasure, business or hire):

Upon whose authority was the driver operating the car?

Any intoxicating beverages or drugs consumed?

THE ACCIDENT OR OCCURANCE

DATE OF ACCIDENT: 20 Hour… AM/PM

Accident Location:

Direction insured's car: Direction other car:

Speed at time of accident : Weather conditions:

What warning given before accident? Were lights lit?

Did a policeman witness or take particulars of the accident?

If so, his name: Address of Police Station:

INJURIES

INJURED PERSON'S NAME: Apparent Age:

Address: (If known) Family:

Occupation: By whom employed?

Nature and extent of injuries

Taken home or to hospital: Attending Doctor's Name:

If to hospital, which one:

Did the injured person make any statement after the accident? (if so, explain on the reverse)

DAMAGE TO PROPERTY OF OTHERS

Name of owner: Address: Phone No:

Name of driver: Address: Phone No:

Make of automobile: Year: Registration No:

Did driver make any comments after the accident?

Name of insurer, if insured: Coverage: Pol. No:

Extent of damage:

Other Property Damaged:

A MEMBER OF THE Assuria Group

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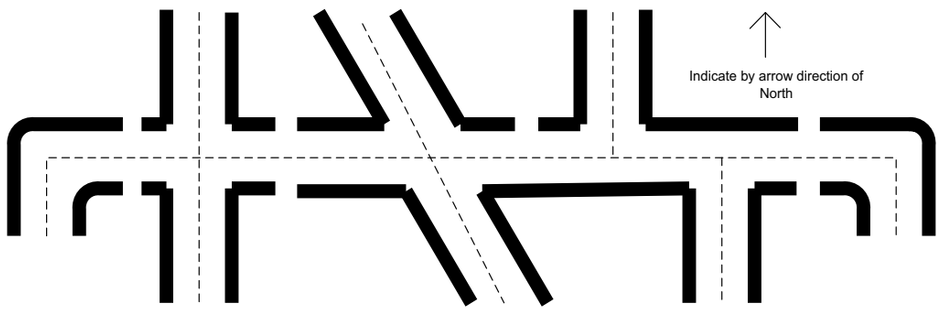
DAMAGE TO AUTOMOBILE OF POLICY-HOLDER	Parts Damaged, and extent: Where may automobile be seen?
	Occupants of Insured's car: Name: Address: Name: Address:
WITNESSES	Occupation of other car (if unknown, show number) Name: Address: Name: Address: Other Witnesses Name: Address: Name: Address:
SKETCH	COMPLETE THE FOLLOWING DIAGRAM SHOWING DIRECTION & POSITIONS OF AUTOMOBILES INVOLVED DESIGNATING CLEARLY POINT OF CONTACT.  Instructions: 1. Use solid line to show path of vehicle before accident ⟶ ▭ - - - - - > ▭ dotted line after accident 2. Number each vehicle & show direction of travel ⟶ ▭ 3. Show motorcycle by ⟶ ○—○ 4. Show pedestrian by ⟶ ○

CLAIMS HISTORY DRIVER/OWNER	No. of Accidents	Details of Accidents	Total Cost of Claims Paid and Outstanding: Own Damage	Third Party
	20 20 20			

DESCRIPTION OF ACCIDENT	
	I declare that these particulars are true and complete Date of Report Signature of Driver_____ Signature if Insured _____