



Guardian Group

Guardian General Insurance Jamaica Limited

Kingston
19 Dominica Drive, P.O Box 401,
Kingston, Jamaica
t: 876 926 3720 f:929 2727

Montego Bay
Lot B15 Fairview II Shopping Centre
P.O Box 170, Montego Bay Jamaica, W.I
t: 876 935 6661 f:876 929 5226

MOTOR VEHICLE ACCIDENT REPORT FORM

The company does not admit liability by the issue of this form
TO AVOID DELAY AND INCONVENIENCE PLEASE ANSWER ALL QUESTIONS FULLY
This form may be returned to you in the event of omissions.

1) **DETAILS OF INSURED**

Policy No.:

Name: Date of Birth

Occupation:

Email Address:

Address:

Tel Nos.: (H) Mobile Office

2) **DETAILS OF DRIVER**

Name: Date of Birth

Address:

Occupation: Place of Issue

No. and Type of Driver's Licence: Expiry Date of Current Licence

Relationship of Driver to Insured Owner Relative or Friend Employee How long employed

Has driver

- (a) Been convicted of any driving or motoring offence within the last 5 years of is any prosecution pending? Yes No
- (b) Been involved in an accident during the last 5 years? Yes No
- (c) If vehicle was driven other than by the insured, does Driver own a Motor Vehicle? Yes No

3) **PARTICULARS OF USE**

Was the vehicle being used on Insured's order or with permission? Yes No

State fully the purpose for which the vehicle was being used at the time of the accident

4) **PARTICULARS OF MOTOR VEHICLE CONCERNED**

Make of Vehicle	Type of Body	Year of Make	Reg. Letter and No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Is there any mortgage interest on the vehicle? Yes No

5)

PARTICULARS OF DAMAGE TO INSURED'S VEHICLE

Full Details of Damage

[Empty text box for full details of damage]

Estimated Cost of Repairs J\$ []

(Please submit detailed repair estimate)

Have you given any instructions as to Repairs being started? Yes No Is your vehicle still in use? Yes No

Where can the vehicle be inspected? []

Was the vehicle removed by wrecker? Yes No

If 'yes' Give name of wrecker company []

6)

PARTICULARS OF ACCIDENT

Date of Accident [] Time []

Place [] Weather/Visibility []

If after lighting time, state which of your light were lit []

Estimated speed of your vehicle [] Condition of road surface []

Did you sound your horn? Yes No If so, how many times []

Give full details of how Accident/Loss or Damage occurred

[Large dashed border area for full details of accident/loss or damage]

Driver's Signature _____

Has notice of any claim been given to you or the driver? Yes No

7) **Sketch of Accident** - Please make a rough sketch showing traffic lights, signs, warnings, etc. where appropriate and position of vehicles indicating how far vehicles were from side of road. An arrow should indicate the direction in which they were moving.

Did the Police witness accident Yes No

Was Accident/Theft reported to Police? Yes No

Which Police Station?

Who in your opinion is to be blamed for the Accident

8)

PARTICULARS OF OCCUPANTS OF INSURED

How many persons were being conveyed in the vehicle?

Were they charged a fee? Yes No

Were the passengers wearing seat belts? Yes No

Were the occupants injured? Yes No

Were goods being carried? Yes No

Did you charge a fee? Yes No

Name	Addresses	Relationship with the Insured	Nature of Injury hospital attended (if any)

9)

WITNESSES

It is the utmost importance always to obtain the names and addresses of witnesses

Full Name	Address	Telephone No.
independent Witnesses		
independent Witnesses		

10)

PARTICULARS OF OTHER VEHICLE OR PROPERTY INVOLVED IN ACCIDENT

1) Name of Owner	<input type="text"/>	Regn. No. of Vehicle	<input type="text"/>
Address of Owner	<input type="text"/>	Make of Vehicle	<input type="text"/>
Name of Driver	<input type="text"/>		
Address of Driver	<input type="text"/>		
Name of Insurers	<input type="text"/>	Policy Number	<input type="text"/>
		Type of Cover	<input type="text"/>

Full Details of damage to vehicle or other property (such as walls, fences, cultivations, animals)

2) Name of Owner	<input type="text"/>	Regn. No. of Vehicle	<input type="text"/>
Address of Owner	<input type="text"/>	Make of Vehicle	<input type="text"/>
Name of Driver	<input type="text"/>		
Address of Driver	<input type="text"/>		
Name of Insurers	<input type="text"/>	Policy Number	<input type="text"/>
		Type of Cover	<input type="text"/>

Full Details of damage to vehicle or other property (such as walls, fences, cultivations, animals)

Any communication you receive regarding the accident should be sent to the Company immediate unanswered.

PARTICULARS OF INJURY TO OCCUPANTS OF THIRD PARTY'S VEHICLE

Were there any passengers in the other vehicle?

Yes No

If yes, how many?

Name	Addresses	Whether, driver passenger, cyclist or pedestrian, etc.	Nature of Injury hospital attended (if any)

I/We declare that the information given in this form is true and correct to the best of my/our knowledge/belief. I/We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

Date

Insured's Signature _____

Date

Driver's Signature _____