INSURANCE COMPANY (JAMAICA) LIMITED

58 Half Way Tree Road
P.O. Box 631, Kingston 10, Jamaica
Telephone: 929-8450-1/4, 929-9643-8, Fax No.: 929-2376, 929-6764
E-mail: info@genac.com Website: www.genac.com

MOTOR ACCIDENT REPORT FORM

Please print clearly, answer all questions accurately and honestly, and provide a copy of a Government-issued PICTURE ID for the person witnessing this form

It is necessary to carefully complete the form and the information provided herein should be strictly accurate, irrespective of whether or not it is in the Insured's favour.

INSURED'S INFORMATION

Name _____ Occupation _____

Home Address _____ Telephone No. _____

Business Address _____ Telephone No. _____

Email Address _____

PARTICULARS OF INSURANCE

Policy No._____ Type of Policy_____ Renewal Date _____

Name of any Bank or Financial Institution with a financial interest in the vehicle_____

Name of any other individual with a financial interest in the vehicle _____

Type of Road Licence: Private, Private CMC, Public CMC or PPV _____

PARTICULARS OF VEHICLE

Licence Plate No._____ Year of Vehicle_____ Make and Model _____

Colour_____ Indicate any unrepaired damage to vehicle _____

Condition of the tyres_____ What was the vehicle being used for? _____

Were goods being carried? ○ Yes ○ No If yes, please state_____

Number of persons in vehicle (including the driver) _____ Were they charged a fee? ○ Yes ○ No

PARTICULARS OF PERSON DRIVING

Driver's Name_____ Occupation_____

Driver's Address_____ Telephone No. _____

Driver's Licence No._____ Original Issue Date _____ At which tax office?_____

Type of Road Licence: Private, Private CMC, Public CMC or PPV _____

Licenced to drive _____

Date of Birth_____ Is the driver employed to the insured? ○ Yes ○ No If yes, give details, below:

_____

How many accidents have you been involved in?_____ Give details below :

_____

Were you wearing a seatbelt? ○ Yes ○ No For motorcycles only: Were you wearing a helmet? ○ Yes ○ No

Were you using a cellular phone at the time of the accident? ○ Yes ○ No Have you suffered from Diabetes

Fits or Heart Complaint or have any physical or mental infirmity? ○ Yes ○ No If yes, give details below:

_____

Has any Insurance Company refused or declined to continue any motor insurance for you? ○ Yes ◉ No

If the vehicle was not being driven by the insured, on whose authority was it being used? _____

What is the relationship between the policy holder and the driver? _____

Was the policyholder in the vehicle at the time of the accident? ○ Yes ○ No

PARTICULARS OF ACCIDENT

Date of Accident _____ Time of Accident _____

Location of Accident _____ Was it reported to the police? ○ Yes ○ No

Police Station _____ Name of Officer _____ Badge No. _____

Were you warned for prosecution? ○ Yes ○ No Was the other driver warned for prosecution? ○ Yes ○ No

What was the weather condition like? _____

Was the pavement wet? ○ Yes ○ No Was visibility good? _____

Who do you think was at fault and why? _____

Did the other driver say he/she would be making a claim? ○ Yes ○ No Are you making a claim? ○ Yes ○ No

Were pictures taken on the scene of the accident? ○ Yes ○ No If yes, kindly submit the images.

PARTICULARS OF DAMAGE TO OWN VEHICLE

	Insured's Vehicle	Third Party 1	Third Party 2
Direction of travel			
On which side of the road			
Speed before accident (km/h)			
Speed after accident (km/h)			
Light (on/off, dim/bright)			
Was horn sounded?			
Was indicator on or off?			

IN ALL CASES WHERE YOUR VEHICLE IS DAMAGED AND YOU ARE ENTITLED TO CLAIM UNDER YOUR POLICY, PLEASE SUBMIT AN ESTIMATE OF REPAIRS TO THE COMPANY WITHIN 30 DAYS OF THE ACCIDENT, AFTER WHICH YOU WILL NO LONGER BE ENTITLED TO SETTLEMENT OF YOUR CLAIM.

Was the vehicle damaged? ○ Yes ○ No If so, state the damage: _____

Approximate cost of repairs _____ Where can the vehicle be inspected? _____

Name and Address of your repairer _____

Was REACT called to the scene? ○ Yes ○ No Did a wrecker move the vehicle? ○ Yes ○ No

Were fees paid? ○ Yes ○ No

PARTICULARS OF PASSENGERS IN INSURED'S VEHICLE

NAME	ADDRESS	OCCUPATION	AGE	RELATIONSHIP TO INSURED	INJURY & HOSPITAL ATTENDED

PARTICULARS OF THIRD PARTIES INVOLVED

PEDESTRIAN, CYCLIST OR PROPERTY/BUILDING

Name and address of pedestrian, cyclist, or pillion _____

Nature of injury to pedestrian, cyclist or pillion _____

If property/building involved, state owner and location _____

Damage to property/building _____

VEHICLE #1 DETAILS

Name and Address of owner _____ Telephone No. _____

Name and Address of driver _____ Telephone No. _____

Licence Plate No. _____ Year _____ Type of Vehicle _____ Colour _____

Insurance Company _____ Driver's Licence No. _____

Nature of Damage _____ Estimated Cost of Repairs _____

How many passengers (no. of males/females)? _____ How many were injured? _____

VEHICLE #2 DETAILS

Name and Address of owner _____ Telephone No. _____

Name and Address of driver _____ Telephone No. _____

Licence Plate No. _____ Year _____ Type of Vehicle _____ Colour _____

Insurance Company _____ Driver's Licence No. _____

Nature of Damage _____ Estimated Cost of Repairs _____

How many passengers (no. of males/females)? _____ How many were injured? _____

DID THE DRIVER OR THE OWNER OF THE THIRD PARTY VEHICLE SIGN A WRITTEN ADMISSION OF LIABILITY? ○ **YES** ○ **NO**

IF YES, PLEASE ATTACH TO THIS CLAIM FORM.

INDEPENDENT WITNESS(ES) – NOT PREVIOUSLY KNOWN TO THE INSURED OR TRAVELLING IN THE INSURED'S VEHICLE

NAME	ADDRESS	TELEPHONE NO.

LEGAL PROCEEDINGS: Please confirm your agreement with the following:

(1) You and/or your driver will co-operate with any investigation surrounding this incident.
(2) Your driver, if required, will attend court to give evidence regarding the accident.
(3) You are willing to have General Accident's appointed Attorney-at-Law handle any legal claim, court matter or lawsuit arising out of this accident.
(4) General Accident's Attorney-at-Law reserves the right to dispose of the Suit in the manner that they think appropriate, although they may solicit your comment of opinion from time to time.
(5) You are willing, if necessary, to assist our Process Server in whatever manner possible and specifically with regards to serving of documents to the Third Party.
(6) Any communications that you received should not be answered but sent to the General Accident immediately.

Date_____ Insured's Signature_____ Driver's Signature_____

STATEMENT- MUST BE COMPLETED BY DRIVER

State fully the particulars or circumstances leading to the acident, and what happened after.

My name is_____ and I live at _____

_____ in the Parish of_____ . I was born on_____

I am a _____ employed to _____ . I am the holder of a_____ Driver's Licence which was issued on_____ and allows me to operate

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Every letter, claim, summons and process shall be notified and forwarded to General Accident Insurance Company (Jamaica) Limited immediately on receipt without any admission of liability by you.

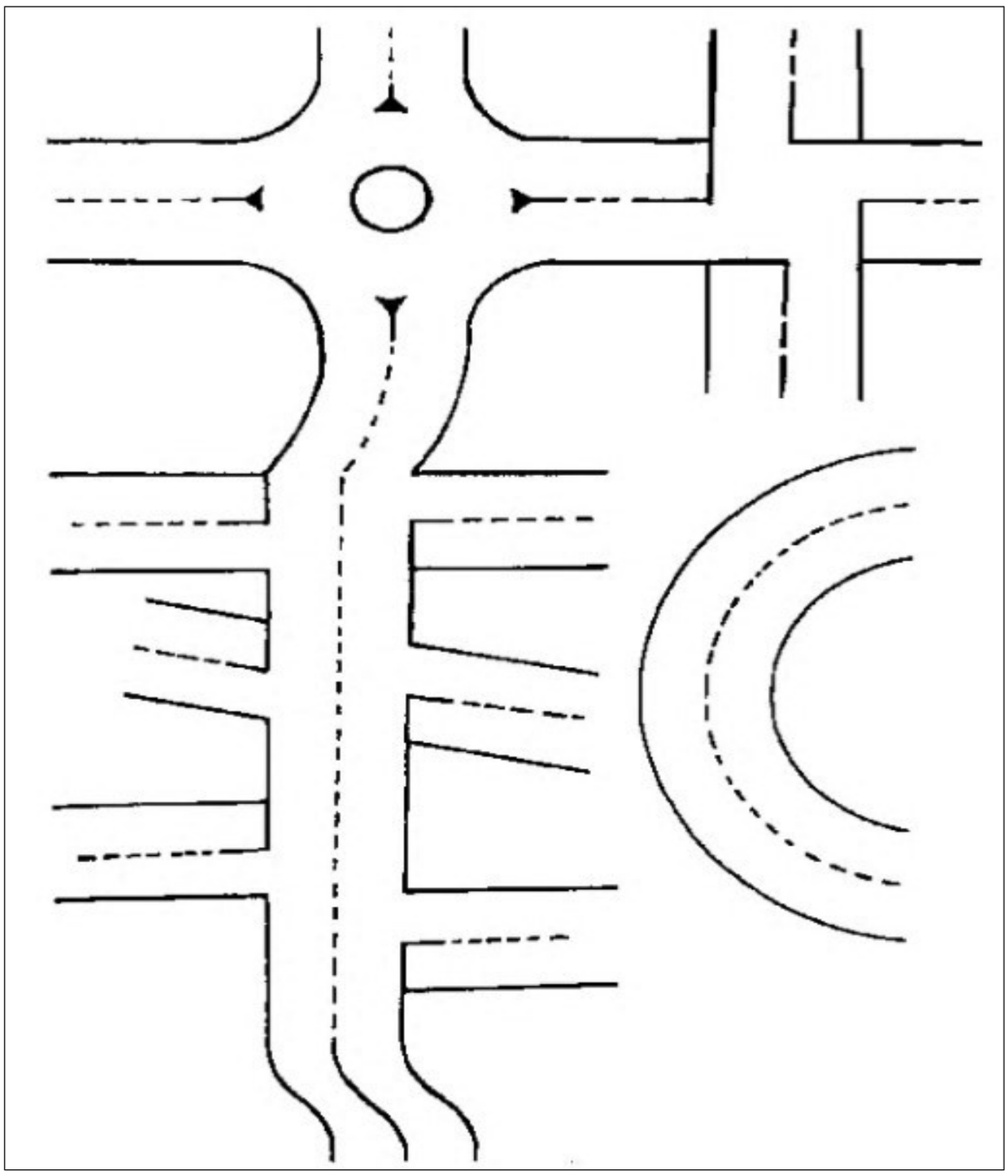
I/We hereby declare that the foregoing particulars given by me/us have been read over and found to be true and correct in every respect, and I/We agreed that if I/We have made, or in any further declaration General Accident may require in respect of the said accident shall make, any false or fraudulent statement, or if found guilty of any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accidents shall be forfeited.

Insured's Signature _____ Date _____

Driver's Signature _____ Date _____

Witness Name _____ Date _____

Witness TRN _____ Signature _____



Please indicate damage to your vehicle, as well as to the Third Party’s vehicle below