

ACCIDENT REPORT FORM

Complete both sides of this form to gather information at the accident scene that is required to document this accident. Make sure you document the other driver's information as well as list any passengers of the vehicles and witnesses to the accident. Submit the completed form to the individual in your district/authoriity who is responsible for monitoring and reporting accidents to the Fund. If you have any questions or need assistance, contact the Fund during regular business hours (8AM to 5PM, Monday through Friday) at 1-800-580-8922.

				IVII	IBER INFORMATION	ON:			
Member N	Name:				Contact Pers	on:			
				С	Contact Phone Numb				
	(1	Keep this	s form in v	our glov	e box and use it in o	case you	have an accid	ent.)	
	(-	10 0 p	,		CIDENT INFORMATION	_		,	
DATE OF L	DATE OF LOSS (MM/DD/YY:)		F LOSS:	AM	LOCATION OF ACCIDENT (Include City and State):				
				PM					
POLICE CONTACTED: 0		OFFICE	OFFICER'S NAME:				POLICE R	NUMBER:	
Yes No									
DESCRIPTION	ON OF ACCIDENT:	Were you	u ticketed?	Yes N	lo If yes, what was	the ticket	for?		
				DESC	CRIBE WHAT HAPPEN	ED:			
<u> </u>									
}									
ļ									
İ									
				Your	VEHICLE INFORMAT	ION:			
YEAR:	EAR: MAKE: MODEL:								
									LICENSE PLATE #:
DRIVER'S N	DRIVER'S NAME: DAT							,	LICENSE PLATE #:
					OF BIRTH (MM/DD/YY	'):	DRIVER'S LIC	_	LICENSE PLATE #:
DRIVER'S HOME ADDRESS:								ENSE N	
DRIVER'S F	HOME ADDRESS:				OF BIRTH (MM/DD/YY		DRIVER'S LIC	ENSE N	
DRIVER'S H	HOME ADDRESS:			DRIVE		DATE		ENSE N	
DRIVER'S F	HOME ADDRESS:			DRIVE	ER'S WORK PHONE:	DATE DATE (List rest	DRIVER HIRED: LICENSE EXPIR	ENSE N	UMBER & STATE:
DRIVER'S F		No		DRIVE	ER'S WORK PHONE:	DATE DATE (List rest	DRIVER HIRED: LICENSE EXPIR	ENSE N	UMBER & STATE:
INJURIES:		No		DRIVE	ER'S WORK PHONE:	DATE DATE (List rest	DRIVER HIRED: LICENSE EXPIR	ENSE N	UMBER & STATE:
INJURIES:	Yes	No		DRIVE	ER'S WORK PHONE: ER'S HOME PHONE: S WHERE VEHICLE CA	DATE DATE (List rest	DRIVER HIRED: LICENSE EXPIR	ENSE N	UMBER & STATE:
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INJURED INDIVIDUALS:									
	NAMES AND ADDRESS:		PHONE(S):	AGE:	LOCATION:	EXTENT OF INJURY:			
		Hor	ne:		Pedestrian	Describe:			
					Insured Vehicle				
		Wo	rk:		Other Vehicle				
						Initial Treatment:			
		Hor	ne:		Pedestrian	Describe:			
					Insured Vehicle				
		Wo	rk:		Other Vehicle				
						Initial Treatment:			
		Ног	ne:		Pedestrian	Describe:			
		14/-			Insured Vehicle				
		Wo	rk:		Other Vehicle				
						Initial Treatment:			
7. WITNESSES OR PASSENGERS:									
	NAMES AND ADDRESS:	Pł	HONE(S):		LOCATION:	DETAILS:			
		He	ome:		Pedestrian				
					Insured Vehicle				
		W	ork:		Other Vehicle				
		Н	ome:		Pedestrian				
					Insured Vehicle				
		W	ork:		Other Vehicle				
3.	Weather:	ather: Surface:				Involved With:			
	Clear	Dry	1		<yux<sup>*Cb</yux<sup>	Moving Vehicle			
	Cloudy	Wet			Side Swipe	Parked Vehicle			
	Rain/Snow	Snow/Ice		Rear End		Pedestrian			
	Fog				Side Impact	Bike/Cycle			
	3					Animal			
						Fixed Object			
	Completed by:	Date:							

Toll-Free Number for Automobile Claims 1-800-580-8922

Complete and Return to 3896TWCARMF@sedgwick.com