

**HUBBARD
INSURANCE
BROKERS**

PHONE: 905-712-4668

FAX TO: 905-712-3586

**AUTOMOBILE REPORT
NOTICE OF ACCIDENT**

POLICY HOLDER	Name: _____ Address: _____	Policy No: _____ Business Phone No: _____
INSURED VEHICLE, DRIVER AND USE	Tractor-Bus: Year _____ Make: _____ Serial No: _____ Trailer- Bus: Year _____ Make: _____ Serial No: _____ Owner of Above Tractor: _____ Was equipment being operated about business of Assured: _____ Name of Driver: _____ Address: _____ Driver's Licence No: _____	Lic. No: _____ Prov.: _____ Lic. No: _____ Prov.: _____ Trailer: _____ Other Insurance Available: _____ Phone No: _____ Age: _____ No. of Hours on Duty: _____
CARGO LOSS	Type of loss and commodity: _____ Present Location: _____	Bill of Lading Enclosed: No _____ Yes _____
DETAILS OF ACCIDENT	Date: _____ 19 _____ Time: _____ am/pm _____ Place: _____ Police Report Made To: _____ City - Officers Number _____ Any Charges Laid: _____ What Charge: _____	Weather Conditions _____ Conditions of Road: _____ City or Town: _____ Province: _____ Against Whom: _____
DAMAGE TO VEHICLE OF POLICY HOLDER	COLLISION: _____ FIRE: _____ THEFT: _____ Present Location of Assured's Vehicle? _____ Assureds Estimate of Damage: _____ Can Assured Complete Repairs? _____ Were Temporary Repairs Made: _____	OTHER: _____ Truck: _____ Tractor: _____ railer: _____ Bus: _____ Amount: _____
DAMAGE TO PROPERTY OF OTHERS	Owner of Vehicle: _____ Address: _____ Licence No: _____ Phone _____ Damage: _____ Insurance Company: _____ Owner of Vehicle: _____ Address: _____ Licence No: _____ Phone _____ Damage: _____ Insurance Company: _____	Driver of Vehicle: _____ Year and Make of Vehicle: _____ Licence No: _____ Policy No: _____ Province: _____ Driver of Vehicle: _____ Year and Make of Vehicle: _____ Licence No: _____ Policy No: _____ Province: _____
INJURED	(1) Name: _____ Address: _____ Phone: _____ Age: _____ Injuries: _____ Doctor: _____ Hospital: _____	(2) Name: _____ Address: _____ Phone: _____ Age: _____ Injuries: _____ Doctor: _____ Hospital: _____
		(3) Name: _____ Address: _____ Phone: _____ Age: _____ Injuries: _____ Doctor: _____ Hospital: _____

OCCUPANTS OF INSURED VEHICLE

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

OCCUPANTS OF OTHER VEHICLE:

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

IMPORTANT: INDEPENDENT WITNESSES: (Include names of bystanders who saw accident, or heard any statements made)

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

NAME: _____ ADDRESS: _____ PHONE: _____

THE ACCIDENT	POLICYHOLDER'S VEHICLE:	OTHER VEHICLE:
	SPEED:	SPEED:
	Before The Accident: _____ km/h	Before The Accident: _____ km/h
	At Instant of Accident: _____ per hour	At Instant of Accident: _____ per hour
	LIGHTS: _____ (ON - OFF - DIM - BRIGHT)	LIGHTS: _____ (ON - OFF - DIM - BRIGHT)
Which Side of Road _____ Warning: _____	Which Side of Road _____ Warning: _____	
Direction Travelled: _____	Direction Travelled: _____	

DRIVER'S STATEMENT OF HOW ACCIDENT OCCURRED:

What part of your vehicle and what part of other car were first in touch? _____

Whom do you consider is responsible? _____

Date Signed: _____ Signature of Driver: _____

Date Reported: _____ How Reported: _____ Phone: _____ Wire: _____ Letter: _____ In Person: _____ Time: _____

Attach a diagram to further explain accident, show points of compass, name of streets, direction of cars and position of cars at instant of accident