



# EQUITY INSURANCES LIMITED

"Briarfield", Lower Collymore Rock, St. Michael BB11115, Barbados, West Indies

Tel: (246) 429-2920 Fax: (246) 429-2957

AGENTS AND MANAGERS FOR: FIRST EQUAL INSURANCE CO. LTD.

## MOTOR VEHICLE ACCIDENT REPORT FORM

Company		Claim No:	
<b>1. THE INSURED</b>			
Name:		Mobile No:	
Home Address:		Tel. No:	
Business Address:		Tel. No:	
Occupation:		Date of Birth/ID No:	
<b>2. THE POLICY</b>			
Policy No.		Renewal Date:	Excess applicable: \$
Coverage:		Insured Value: \$	
Is premium paid?		If not, why not?	
<b>3. THE INSURED VEHICLE</b>			
Reg. No:	Year:	c.c.	Eng. No:
Make & Model:		Colour:	Chassis No:
Is Vehicle:	Left Hand Drive?	Van?	Motor Cycle?
Truck?	Special Licence?		
Exactly what was vehicle being used for?			
Name of owner of vehicle:			
Was the vehicle being used with owner's consent?			
Specify any mortgage /hire purchase agreement on your vehicle:			
How many passengers were being carried?		Were they fare paying?	
If goods were being carried state:		a) Owner	
		b) Description	
<b>4. THE DRIVER</b>			
Name:		Male or Female:	Mobile No:
Home Address:		Tel. No:	
Business Address:		Tel. No:	
Occupation:		Date of Birth/ID No:	
Is the Driver employed by you?		State year licence originally passed:	
Driver's Licence No: (Please attach Photocopy)		Date of Issue:	
Type of Licence:		Date of Expiry:	
What is the relationship of the Driver to the policy holder?			
Has the Driver any motoring convictions/offences or licence endorsements/suspensions? (Give details)			
Has the Driver had any previous accidents? (Give details)			
Has the Driver ever been refused any type of insurance?		Had the Driver been drinking alcohol/taking drugs?	
Does the Driver own a vehicle?		Where is it insured?	
Has the Driver any physical infirmity or defective vision or hearing, or lost a limb or an eye?			
If yes, what?			



8. OTHER VEHICLE OR PROPERTY CONNECTED WITH THE ACCIDENT			
Particulars	Vehicle 1	Vehicle 2	Vehicle 3
Reg. No:			
Make & Model:			
Name of Owner:			
Address:			
Tel. No:			
Name of Insurer:			
Driver's Name:			
I.D. No./Date of Birth:			
Address:			
Occupation:			
Tel. No:			
Name of Insurer:			
Description of Damage:			
Details of Damage to other Property:			
Name of Owner:			

ALL COMMUNICATIONS RECEIVED FROM OR ON BEHALF OF ANY CLAIMANT MUST BE FORWARDED TO US IMMEDIATELY

I/We hereby declare that the foregoing particulars by me/us are true in every respect:

Driver's signature: \_\_\_\_\_ I.D. No. \_\_\_\_\_ Date \_\_\_\_\_

Insured's signature: \_\_\_\_\_ I.D. No. \_\_\_\_\_ Date \_\_\_\_\_

(Please use next page for a diagram of the accident)

**For Office Use Only**

	Seen/Copied	Signature	Date
1) Driver's Licence	<input type="checkbox"/> <input type="checkbox"/>		
2) Certificate of Insurance	<input type="checkbox"/> <input type="checkbox"/>		
3) Identification Card	<input type="checkbox"/> <input type="checkbox"/>		

