



GK GENERAL INSURANCE COMPANY LIMITED

NEW KINGSTON
Knutsford Boulevard

LIGUANEA
Sovereign Ctr.

DOWNTOWN
Duke Street

MANDEVILLE
Midway Mall

MONTEGO BAY
Fairview Shopping Ctr.

PORTMORE
Portmore Town Ctr.

Toll Free: 1-888-429-5GKG (429-5454) | Fax: 876-968-1920 | Email: gkinfo@gkco.com | Website: www.gkgeneral.com

MOTOR ACCIDENT REPORT FORM

The report is made in the bona fide belief that litigation may ensue, and to enable the Company's representatives and Attorneys to conduct such litigation and advise in relation thereto.

It is necessary therefore, that great care should be taken in completing this form and the information given herein should be strictly accurate, irrespective of whether it is in the Insured's favour or otherwise.

PARTICULARS OF INSURED

Name _____	TRN _____
Home Address _____	Date of Birth _____
Contact _____ (C) _____	(H) Email _____
Occupation _____	Employer _____
Business Address _____	Business No. _____

INSURANCE INFORMATION

Policy # _____	Type of Policy _____	Type of Cover _____
Period of Insurance _____	Insured Value _____	Excess _____
Last Valuation Value _____	Restrictions _____	

VEHICLE DETAILS

Licence Plate No. _____	Make _____	Model _____	Year _____
Colour _____	Left/Right Hand Drive _____	Condition of Tyres _____	
Was there any unrepaired damage prior to the accident? _____			
Type of Road Licence (i.e Private Car, Private C.M.C., Public C.M.C or PPV) _____			
Name & Address of Bank or Company with Financial Interest in the Vehicle _____			

USE OF THE VEHICLE

State the exact purpose for which the vehicle was being used at the time of the accident _____	
_____	Were goods being carried? _____
If so, state the nature of the goods and weight _____	
How many persons including the driver were in the vehicle? _____	Were they being charged a fee? _____
If the vehicle was being driven by a person other than the Insured, with whose permission was it being used? _____	
Was the vehicle being used for hire or reward? _____	Was the Insured in the vehicle when the accident took place? _____

DRIVER – IF OTHER THAN THE INSURED

Name _____ Date of Birth _____

Address _____ Contact © _____

Occupation _____ Employer _____ Driving Experience _____

Driver's Licence/Permit No. _____ Date Issued _____ Which Tax Office _____

Type of Licence (PVT, GEN, GEN TO INC PPV, FOREIGN COUNTRY) _____ How many accident in the last 3 years? _____

Has the licence been endorsed? _____ If so, give particulars _____

What is the relationship between the driver and the Insured? _____ Was the driver drinking? _____

Does driver own a vehicle? _____ If so, where is it insured? _____

Does the driver suffer from any physical infirmity, defective hearing or vision? _____

THE ACCIDENT

Date of Accident _____ Time _____ am/pm Place _____ in the vicinity of _____

Condition of the Road _____ Type of Surface _____ Weather _____

Who caused the accident _____ Did the police investigate? _____ Did they visit the Scene? _____

Police Station _____ Name of Police Officer _____ Badge No. _____

Were you warned for prosecution? _____ Was the other person warned for prosecution? _____

Did the driver of the other vehicle seem to be under the influence of liquor? _____

Have you received any indication of a claim from the third party? _____

Did the driver of the other vehicle make any statement bearing on the accident? _____

Did the driver or owner sign written admission of liability? _____

	INSURED'S VEHICLE	THIRD PARTY #1	THIRD PARTY #2
DIRECTION OF TRAVEL			
ON WHICH SIDE OF THE ROAD			
SPEED BEFORE ACCIDENT			
SPEED AT THE TIME OF ACCIDENT			
LIGHTS (On, Off, Dim or Bright)			
WAS HORN SOUNDED			
WAS INDICATOR ON OR OFF			

DAMAGE TO INSURED'S VEHICLE

List damage to the vehicle _____

What is the estimated repair cost? _____ Name & No. for your Repairer _____

Was a wrecker used to remove the vehicle? _____ Name & No. of the Wrecker Co. _____

Where can the vehicle be inspected? _____

PASSENGERS IN INSURED'S VEHICLE

NAME	ADDRESS	OCCUPATION	AGE	RELATIONSHIP TO THE INSURED	NATURE OF INJURY/HOSPITAL ATTENDED

INDEPENDENT WITNESS – NOT PREVIOUSLY KNOWN TO INSURED

NAME	ADDRESS	CONTACT NUMBER

THIRD PARTIES INFORMATION

IF PEDESTRIAN OR CYCLIST PLEASE STATE:

- a) Name and Address _____ Contact No. _____
- b) Nature if Injury if any _____
- c) Damage to cycle _____

VEHICLE DETAILS

- a) Owner’s Name and Address _____ Contact No. _____
- b) Driver’s Name & Address _____ Driver’s Licence No. _____
- c) Licence Plate No. _____ Year _____ Type of Vehicle _____ Colour _____
- d) How many passengers were in the vehicle? _____ How many were injured? _____
- e) Insurance Company _____ Nature of Damage _____ Estimated Cost of Repairs _____

VEHICLE DETAILS

- a) Owner’s Name and Address _____ Contact No. _____
- b) Driver’s Name & Address _____ Driver’s Licence No. _____
- c) Licence Plate No. _____ Year _____ Type of Vehicle _____ Colour _____
- d) How many passengers were in the vehicle? _____ How many were injured? _____
- e) Insurance Company _____ Nature of Damage _____ Estimated Cost of Repairs _____

THIRD PARTY INJURY DETAILS

NAME	ADDRESS	OCCUPATION	AGE	INJURY

LEGAL PROCEEDINGS

Please confirm your agreement to the following:

- a) You/Your driver will attend Court to give evidence regarding this accident.
- b) You are willing to have GK General’s Attorneys-at-Law handle the Suit.
- c) GK General’s Attorneys reserve the right to dispose of the Suit in the manner that they think is appropriate, although, they may solicit your views from time to time.
- d) You are willing if necessary to assist our process server in whatever manner possible and specifically regarding serving the Third Party.

Date _____ Insured’s Signature _____ Driver’s Signature _____

STATEMENT – TO BE COMPLETED BY THE DRIVER

State fully the circumstances of the accident 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 _____

which allows me to operate _____. My licence was issued at _____

on _____. I have never been charged/convicted in connection with any traffic offences.

Enter the statement in the box below:

(Any communications that you receive about the accident should not be answered, but sent to the Company immediately)

I DECLARE that these particulars are true and complete.

Dated

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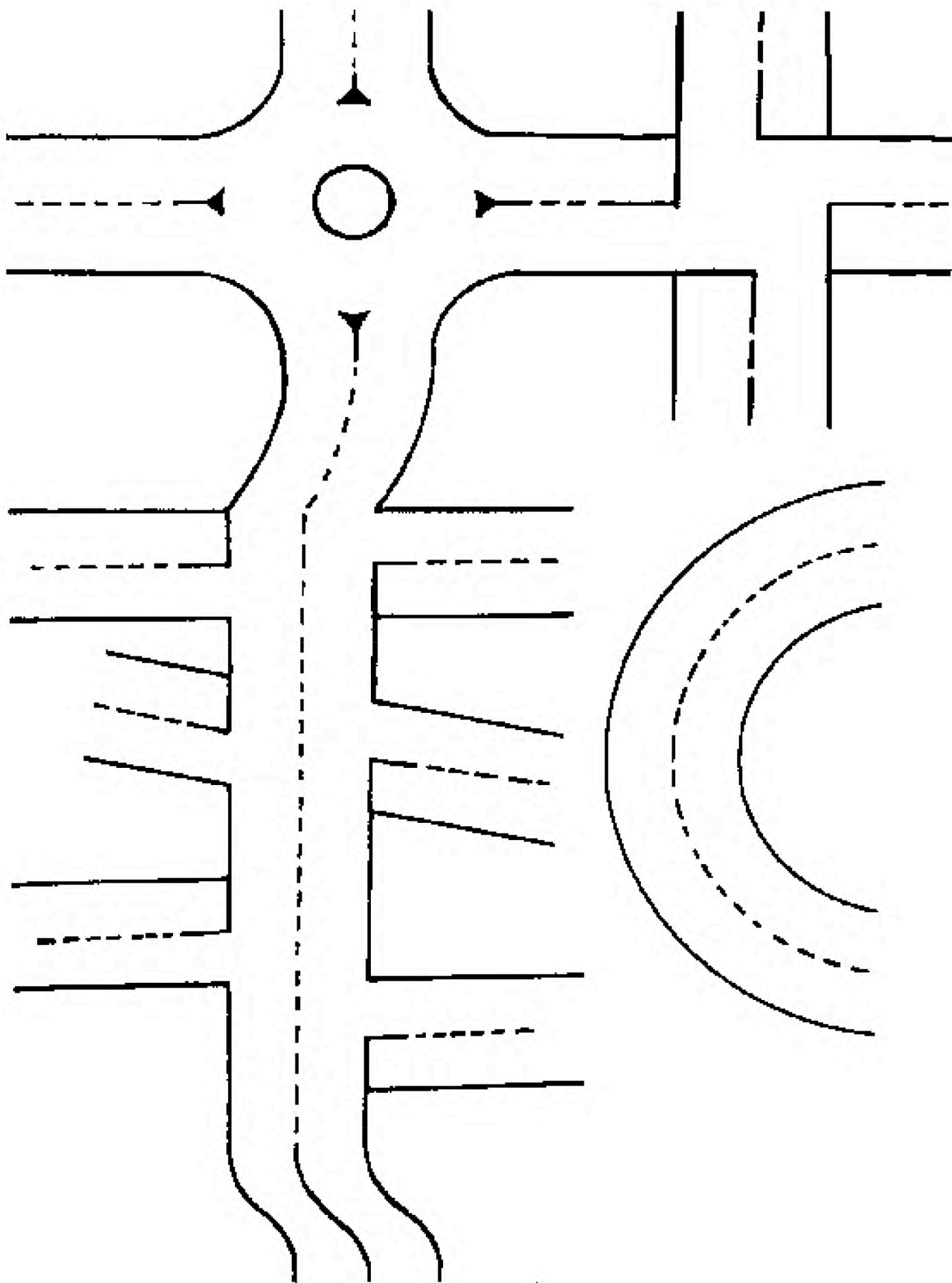
Signature of Insured

—

Signature of Driver

—

PLEASE COMPLETE APPROPRIATE DIAGRAM OVERLEAF.



PLEASE
INDICATE
AREA
OF
DAMAGE

