

agreed statement of facts on motor vehicle accident

Does NOT constitute an admission of liability, but a summary of identities and of the facts which will speed up the settlement of claims.

Must be signed by BOTH drivers

1. date of accident	time	2. place (exact location of accident)	3. injuries even if slight no <input type="checkbox"/> yes <input type="checkbox"/> *
4. property damage other than to the vehicles A and B no <input type="checkbox"/> yes <input type="checkbox"/> *		5. witnesses names, addresses and tel. nos. (to be underlined if it relates to passenger in A or B)	

vehicle A

6. insured policyholder (see insurance cert.)
Name _____
(capital letters)
First name _____
Address _____
Tel. No. (from 9 hrs. to 17 hrs.) _____
Can the Insured recover the Value Added Tax on the vehicle? no yes

7. vehicle
Make, type _____
Registration No. (or engine No.) _____

8. insurance company
Policy No. _____
Agent (or broker) _____
Green Card No. (if issued) _____
Ins. Cert. or Green card } valid until _____
Is damage to the vehicle insured? no yes

9. driver (see driving licence)
Name _____
(capital letters)
First name _____
Address _____
Driving licence No. _____
Groups _____ Issued by _____
valid from _____ to _____

12. circumstances
Put a cross (X) in each of the relevant spaces to help explain the plan.

<input type="checkbox"/>	1	parked (at the roadside)	<input type="checkbox"/>
<input type="checkbox"/>	2	leaving a parking place (at the roadside)	<input type="checkbox"/>
<input type="checkbox"/>	3	entering a parking place (at the roadside)	<input type="checkbox"/>
<input type="checkbox"/>	4	emerging from a car park, from private grounds, from a track	<input type="checkbox"/>
<input type="checkbox"/>	5	entering a car park, private grounds, a track	<input type="checkbox"/>
<input type="checkbox"/>	6	entering a roundabout (or similar traffic system)	<input type="checkbox"/>
<input type="checkbox"/>	7	circulating in a roundabout etc. striking the rear of the other vehicle while going in the same direction and in the same lane	<input type="checkbox"/>
<input type="checkbox"/>	8	going in the same direction but in a different lane	<input type="checkbox"/>
<input type="checkbox"/>	9	changing lanes	<input type="checkbox"/>
<input type="checkbox"/>	10	overtaking	<input type="checkbox"/>
<input type="checkbox"/>	11	turning to the right	<input type="checkbox"/>
<input type="checkbox"/>	12	turning to the left	<input type="checkbox"/>
<input type="checkbox"/>	13	reversing	<input type="checkbox"/>
<input type="checkbox"/>	14	encroaching in the opposite traffic lane	<input type="checkbox"/>
<input type="checkbox"/>	15	coming from the right (at road junctions)	<input type="checkbox"/>
<input type="checkbox"/>	16	not observing a right of way sign	<input type="checkbox"/>
<input type="checkbox"/>	17		<input type="checkbox"/>

◀ State TOTAL number of spaces marked with a cross ▶

vehicle B

6. insured policyholder (see insurance cert.)
Name _____
(capital letters)
First name _____
Address _____
Tel. No. (from 9 hrs. to 17 hrs.) _____
Can the Insured recover the Value Added Tax on the vehicle? no yes

7. vehicle
Make, type _____
Registration No. (or engine No.) _____

8. insurance company
Policy No. _____
Agent (or broker) _____
Green Card No. (if issued) _____
Ins. Cert. or Green card } valid until _____
Is damage to the vehicle insured? no yes

9. driver (see driving licence)
Name _____
(capital letters)
First name _____
Address _____
Driving licence No. _____
Groups _____ Issued by _____
valid from _____ to _____

10. Indicate by an arrow the point of initial impact

11. visible damage

13. plan of the accident

Indicate: 1. the layout of the road - 2. by arrows the direction of the vehicles A, B - 3. their position at the time of impact - 4. the road signs - 5. names of the streets or roads

10. Indicate by an arrow the point of initial impact

11. visible damage

14. remarks

A

15. signatures of the drivers

A **B**

14. remarks

B

LPO 445 DC 15.513

*In the event of injuries or in the event of damage to property other than to the vehicles A and B, give information overleaf.

Do not alter anything in the statement after signature and the separation of the copies for the two drivers.

For Insured's accident report see back →

MOTOR ACCIDENT REPORT

To be completed by the Insured and sent immediately to his Insurers (Use a separate sheet of paper where necessary)

Insured	1 Occupation (if more than one state all) _____				
Insured Vehicle	2 Make/Model/Type	C.C.	If commercial vehicle state carrying capacity and g.p.w.	Date of first registration as new	Registration mark
	Please give/confirm instructions on my/our behalf (where appropriate) for the repairs				
	3 Are you the Owner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, state Owner's name and address _____	
	4 Exact purpose for which vehicle was being used at time of accident _____				
	5 Is the vehicle still in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, state where it is at present _____	
	6 Name and address of Finance Company (if any) _____ Tel. No _____				
Driver or Person in charge of Vehicle (If the Insured complete this section as appropriate)	7 Date of Birth	Occupation (If more than one, state all)	Date driving test passed	Was he driving with your permission	Was he your employee?
				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	8 Give details of any impairment of sight or hearing and of any other disability _____				
	9 Full details of all driving convictions including pending prosecutions				
	Date	Offence	Penalty		
Injured Persons	10 Name(s), Address(es) and approximate Age(s)		Injuries Sustained	If Vehicle Occupants state in which vehicle	Were seat belts being worn?
Damage to Property & Vehicles (other than vehicles 'A' & 'B' overleaf)	11 Owner(s) Name(s) and Address(es)		Details of Vehicle or Property	Nature of Damage	Insurer's Name and Address (if known)
Police Action	12 Was the accident reported to Police?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	If yes, give station and P.C.'s name and number _____				
	13 Was warning of prosecution given?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If yes, against whom? _____					
Accident Details	14 Weather conditions _____				
	15 Speed of vehicles	A <input type="text"/>	B <input type="text"/>		
	16 What warnings were given by driver or other party? _____				
	17 Were street lights illuminated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	18 What lights were displayed on your vehicle/the other vehicle(s) _____				
	19 If your vehicle is commercial state weight of load carried at time of accident _____				
20 State how accident happened, indicating width of roads, speed limits, etc. _____					

Declaration	I/We declare the foregoing particulars are true in every respect.				
	Insured's Signature _____				Date _____