

Driver's Accident Report Form

IN THE EVENT OF AN ACCIDENT

Driver – Complete all items to the best of your ability, sign, and date page 3, and immediately give it to your supervisor.

Supervisor – Fax/Scan this Driver's Accident Report form to your **insurance broker** immediately.

If a claim needs to be reported after business hours or on the weekend, call (484) 821-6449.
This number is reserved for true claims emergencies after business hours and weekends.

Driver/Vehicle Information

Name of Driver (first and last)		Social Security #		Driver License No.	State
Driver's Address – Street	City	State	Zip	Telephone No.	
Vehicle Owner				ANI/NIAC Policy Number	
Employer Name		Insurance Carrier			
Employer Contact Name		Contact Email Address			
Employer Address – Street	City	State	Zip	Telephone No.	
Make/Model/Fleet ID # of Vehicle	Body Type	Year	License Plate #	V.I.N. (last four digits)	
Damage to Vehicle:					

Accident Information

Date of Accident	Day of Week (circle one) Mon Tue Wed Thurs Fri Sat Sun	Time of Accident	Location - Street or Highway & City		
On what street were you driving?			Direction (circle one) N S E W	Speed (approximate)	
On what street was the other vehicle driving?			Direction (circle one) N S E W	Speed (approximate)	
Police Report? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of reporting officer	Reporting officer badge #	Citation/Report #		
Witness #1 Name (first and last)		Telephone No.	Email Address		
Witness #2 Name (first and last)		Telephone No.	Email Address		
Description of Accident (include weather and road conditions):					

(Use the back of this sheet if additional space is needed; please use the diagrams on page 3 to draw the accident)

Passenger(s) in Your Vehicle *(attached additional pages if needed)*

Name (first and last)	Telephone No.	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No.	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name	Telephone No.	Email Address	Age	Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Ambulance called to scene. <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of doctor or hospital			

Other Vehicle Involved

Name of Driver (first and last)			Driver License No.		State
Driver's Address – Street		City	State	Zip	Telephone No.
Name of Vehicle Owner (if different than above)					Telephone No.
Name of Insurance Company			Policy #		Telephone No.
Year/Make/Model/Fleet ID # of Vehicle		Body Type		License Plate No.	State
Damage to Vehicle:					
Passenger's Name (first and last)			Telephone No.		Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)			Telephone No.		Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Vehicle Involved *(if any)*

Name of Driver (first and last)			Driver License No.		State
Driver's Address – Street		City	State	Zip	Telephone No.
Name of Vehicle Owner (if different than above)					Telephone No.
Name of Insurance Company			Policy #		Telephone No.
Year/Make of Vehicle		Body Type		License Plate No.	State
Damage to Vehicle:					
Passenger's Name (first and last)			Telephone No.		Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Passenger's Name (first and last)			Telephone No.		Age Injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No

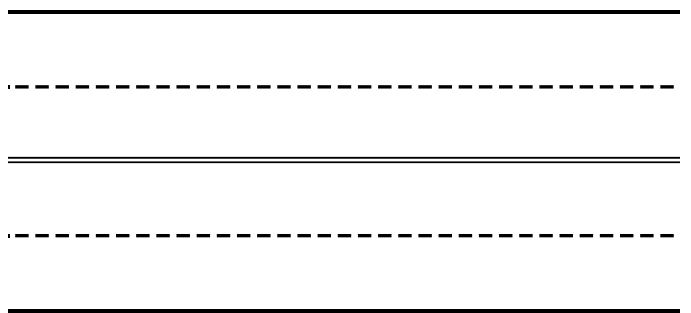
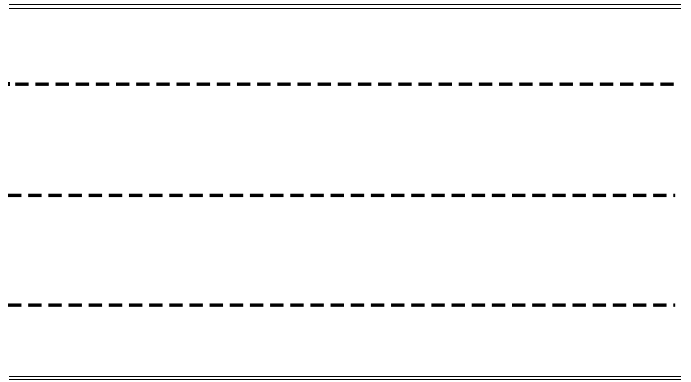
On the diagrams below, please draw the accident.

(Be sure to include any stop signs or traffic signals.)

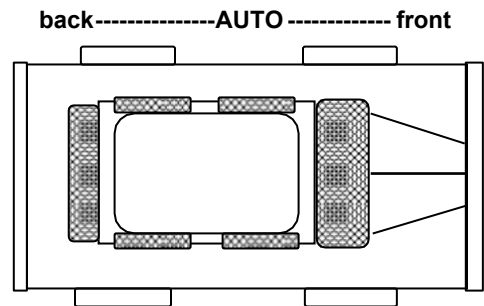
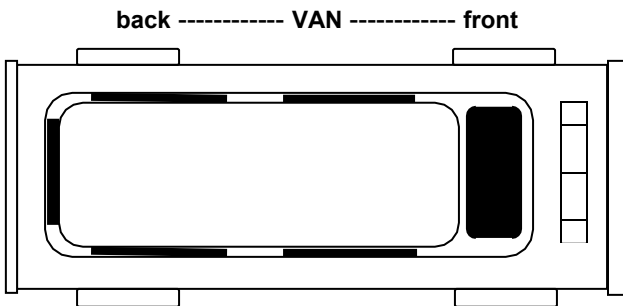
Legend:

- V 1 ▶ Your Vehicle
- V 2 ▶ Other Vehicle
- V 3 ▶ Other Vehicle (if any)

N
W → E
S



On the overhead diagrams below, please indicate the location of damage to *your* vehicle, if any.



SIGNATURE OF DRIVER

DATE