

AUTOMOBILE ACCIDENT REPORT

IBC CLAIM FORM NO. 1

| | | | | | | |
|------------------------------|--|----------------------|--|--|------------------------------|-------------|
| INSURER | | AGENT OR BROKER | | CLAIM NUMBER | | |
| POLICY HOLDER | NAME OF INSURED | | | RESIDENCE PHONE | | |
| | HOME ADDRESS | | | BUSINESS PHONE | | |
| VEHICLE | POSTAL CODE | | | BUSINESS ADDRESS | | |
| | REGISTERED OWNER | | | ADDRESS | | |
| | ACTUAL OWNER | | | ADDRESS | | |
| | MAKE OF VEHICLE | YEAR | MODEL | SERIAL NO. | LICENCE PLATE NO. & PROVINCE | |
| MILEAGE | DESCRIBE DAMAGE | | | ESTIMATE OF DAMAGE | | |
| G.S.T. | IS THE POLICYHOLDER REGISTERED FOR THE GOODS AND SERVICES TAX? | | | IF THE ANSWER IS YES, PLEASE STATE: | | |
| | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | a) Registration Number _____ b) Percent Recoverable _____ | | |
| DRIVER | NAME OF DRIVER | | AGE | STATE ANY PHYSICAL DISABILITIES | | |
| | ADDRESS | | | BUSINESS ADDRESS | | |
| | RESIDENCE PHONE - () | | | BUSINESS PHONE - () | | |
| | DRIVER'S LICENCE NO. | | PROVINCE OF ISSUE | PREVIOUS ACCIDENTS OR CONVICTIONS | | |
| | DATE OF ACCIDENT DAY MONTH YEAR | TIME A.M. P.M. | <input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DUSK <input type="checkbox"/> DARK | LOCATION OF ACCIDENT | | |
| | PURPOSE VEHICLE USED FOR AT TIME OF ACCIDENT | | WEATHER CONDITIONS | | ROAD CONDITIONS | |
| | YOUR SPEED | DIRECTION | OTHER'S SPEED | DIRECTION | | |
| | POLICE INVESTIGATION BY | | | CHARGES | | |
| | HAD YOU TAKEN ANY ALCOHOLIC BEVERAGES OR DRUGS PRIOR TO THE ACCIDENT | | WHO WAS RESPONSIBLE FOR THE ACCIDENT - REASON | | | |
| | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| DAMAGE TO PROPERTY OF OTHERS | NAME | | PHONE | NAME | | |
| | ADDRESS | | PHONE | | | |
| | YEAR AND MAKE OF VEHICLE | | LICENCE NO. | YEAR AND MAKE OF VEHICLE | | LICENCE NO. |
| | NAME OF INSURER | | POLICY NO. | NAME OF INSURER | | POLICY NO. |
| | DESCRIPTION OF DAMAGE | | | DESCRIPTION OF DAMAGE | | |
| | WHERE CAN VEHICLE BE INSPECTED | | | WHERE CAN VEHICLE BE INSPECTED | | |
| | NAME OF DRIVER | | PHONE | NAME OF DRIVER | | PHONE |
| | ADDRESS | | ADDRESS | | | |
| DRIVER'S LICENCE NO. | | PROVINCE OF ISSUE | DRIVER'S LICENCE NO. | | PROVINCE OF ISSUE | |

Continued over

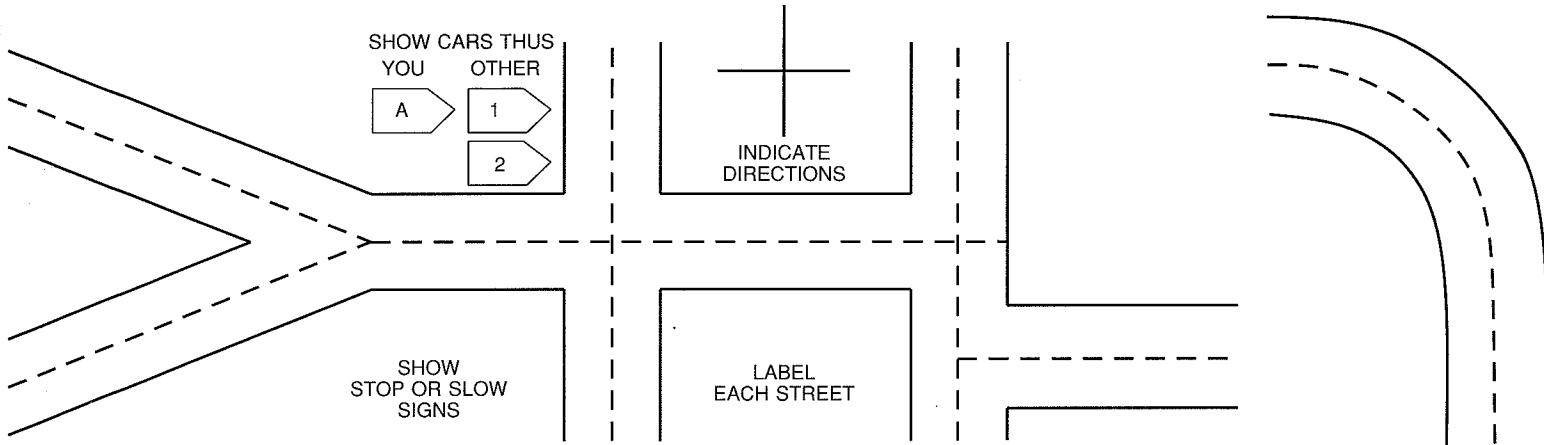
| PERSONS INJURED | NAME | AGE | ADDRESS | PHONE | NATURE OF INJURIES | HOSPITAL |
|-----------------|------|-----|---------|-------|--------------------|----------|
| | | | | | | |

DETAILS OF ACCIDENT

| WITNESSES | NAME: | NAME: | NAME: |
|-----------|---|---|---|
| | ADDRESS: | ADDRESS: | ADDRESS: |
| | PHONE: | PHONE: | PHONE: |
| | IN WHICH CAR? <input type="checkbox"/> YOUR CAR <input type="checkbox"/> OTHER CAR #1 <input type="checkbox"/> OTHER CAR #2 <input type="checkbox"/> OTHER | IN WHICH CAR? <input type="checkbox"/> YOUR CAR <input type="checkbox"/> OTHER CAR #1 <input type="checkbox"/> OTHER CAR #2 <input type="checkbox"/> OTHER | IN WHICH CAR? <input type="checkbox"/> YOUR CAR <input type="checkbox"/> OTHER CAR #1 <input type="checkbox"/> OTHER CAR #2 <input type="checkbox"/> OTHER |

DESCRIPTION OF ACCIDENT

(Illustrate position of cars at time of collision. Show skid marks.)
 (If any street is more than two-lane or is one way only, please indicate.)



DATE: _____ SIGNATURE OF DRIVER: _____

TO BE COMPLETED BY POLICYHOLDER:

| | |
|---|---------------------------------------|
| WHO IS PRINCIPAL DRIVER OF YOUR VEHICLE? | WHAT IS DRIVER'S RELATIONSHIP TO YOU? |
| WAS VEHICLE BEING USED WITH YOUR CONSENT? | LIEN OR MORTGAGE ON VEHICLE TO: |

DATE: _____ SIGNATURE OF POLICYHOLDER: _____