

**THE PREMIER INSURANCE COMPANY OF MASSACHUSETTS
CLAIMANT'S REPORT OF ACCIDENT**

Please print or type

INSURED/CLIENT NAME: _____ CLAIM NUMBER: _____

COMPLETE THIS SECTION FOR ALL CLAIMS

YOUR NAME (OWNER OF VEHICLE) _____
ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE) _____
PHONE NUMBER (____) _____ SOCIAL SECURITY NO. _____ AGE _____
NAME OF EMPLOYER _____ OCCUPATION _____

DATE OF LOSS _____ HOUR OF ACCIDENT _____ AM / PM
WHERE DID ACCIDENT OCCUR? (STREET OR HIGHWAY, CITY OR TOWN & STATE) _____

WAS ANYONE INJURED? (IF YES, GIVE NATURE OF INJURIES-USE SECOND SHEET IF NECESSARY) YES ____ NO ____
NAME OF PERSON(S) INJURED _____
NATURE OF INJURIES _____
AGE _____
WAS SEAT BELT BEING WORN _____
ADDRESS (NO., STREET) _____
(CITY/TOWN, STATE, ZIP) _____
PHONE NUMBER (____) _____ (____) _____ (____) _____

DESCRIBE ACCIDENT(PLEASE DRAW DIAGRAM ON NEXT SHEET - USE SECOND SHEET IF NECESSARY FOR DESCRIPTION)

NAME OF ALL WITNESS (INCLUDE AUTOMOBILE OCCUPANTS)
NAME _____
ADDRESS (NO., STREET) _____
(CITY/TOWN, STATE, ZIP) _____
PHONE NUMBER (____) _____ (____) _____ (____) _____

DID POLICE MAKE REPORT OF THIS ACCIDENT? (IF YES, INDICATE WHICH) YES ____ NO ____
CITY/LOCAL POLICE _____ STATE POLICE _____ OTHER (SPECIFY) _____

SIGN AND DATE IN ALL CASES

I have understood all the questions that I have answered. The answers are true and correct to the best of my knowledge.
SIGNATURE _____ DATE _____

IMPORTANT! COMPLETE APPROPRIATE SECTIONS ON SECOND SHEET

COMPLETE THIS SECTION IF ACCIDENT INVOLVED YOUR AUTOMOBILE

Complete Accident Diagram Below

YOUR AUTO

DRIVER'S NAME _____

ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE) _____

OPERATOR'S LICENSE (STATE & NO.) _____ PHONE NUMBER () _____ NO. OF PERSONS IN AUTO _____

YEAR, MAKE & MODEL OF AUTO _____ VEHICLE LICENSE PLATE (STATE & NO.) _____

WAS DRIVER ON ERRAND FOR YOU? (IF YES, FOR WHAT PURPOSE?) YES _____ NO _____

WHAT PARTS OF YOUR AUTO WERE DAMAGED? _____ AMOUNT OF DAMAGE TO YOUR AUTO? \$ _____

WHO ESTIMATED YOUR DAMAGES? _____ DO YOU CARRY COLLISION INSURANCE? YES _____ NO _____

WHERE MAY YOUR AUTO BE INSPECTED? _____ WHEN? _____

WHAT IS THE NAME AND ADDRESS OF YOUR INSURANCE COMPANY? _____

POLICY NUMBER _____

WHAT IS THE NAME AND ADDRESS OF YOUR AGENT? _____

OTHER AUTO

OWNER'S NAME _____

ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE) _____

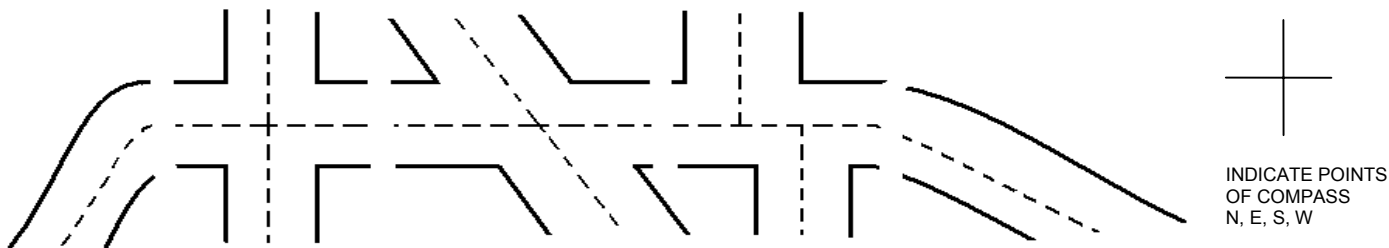
YEAR, MAKE & MODEL OF AUTO _____ VEHICLE LICENSE PLATE (STATE & NUMBER) _____

DRIVER'S NAME _____

ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE) _____

OPERATOR'S LICENSE (STATE & NUMBER) _____ AGE _____ NUMBER OF PERSONS IN CAR _____

	YOUR AUTO	OTHER AUTO
RATE OF SPEED / DIRECTION OF TRAVEL	_____ / _____	_____ / _____
WERE HAND/DIRECTIONAL SIGNALS USED BY EITHER DRIVER?	_____	_____
WEATHER AT TIME OF ACCIDENT	ROAD CONDITION AT PLACE OF ACCIDENT _____	



FILL IN – SHOW HOW ACCIDENT OCCURRED BY USING THIS DIAGRAM

- Use solid line to show path of vehicle before accident and dotted line after accident
- Number each vehicle and show direction of travel by arrow mark your vehicle as #1, all others #2, #3, etc.
- Show pedestrians by
- Railroads by

COMPLETE IF ACCIDENT DAMAGED YOUR PROPERTY – OTHER THAN AUTO

NAME OF OWNER OF PROPERTY DAMAGE _____

PHONE NUMBER () _____

ADDRESS (NO., STREET, CITY/TOWN, STATE & ZIP CODE) _____

DESCRIPTION OF PROPERTY DAMAGED _____