



DONEWELL INSURANCE COMPANY LIMITED

HEAD OFFICE: - H/NO. F333/1, KUKU HILL, OSU R.E.
P. O. BOX 2136, ACCRA.

TEL.: 763065, 763118, 7011560/1, 772778, 760483, FAX: 760484, 763147

E-mail: claims@donewellinsurance.com

MOTOR ACCIDENT REPORT FORM

Notice to Policyholder:

The Company does not admit liability by the issue of this form.

It is necessary that great care is taken in completing this form and the information given therein be strictly accurate, irrespective of whether it is in your favour or otherwise.

Policyholders are advised that in the event of an injury to a Third Party or damage to his property, you should supply the information set out below so as to enable us and our Solicitors give advice thereon and conduct any litigation which may ensue.

You should not make an admission of liability or make a payment offer or promise so as not to prejudice our position.

CHIEF EXECUTIVE OFFICER

1. OFFICIAL USE

- Date Form was collected
- Date Returned.....
- Policy Number.....

2. DETAILS OF INSURED

- 3. Name of Insured.....
- Postal Address.....
- Occupation..... Telephone No:.....
- e-mail

Contact Details

HEAD OFFICE
F333/1 Carl Quist Street
Osu RE, Accra
P.O. Box GP 2136, Accra
Tel: 0302-763065, 772778,763118. Fax: 0302-763147, 760484

DANSOMAN
Dansoman Market,
Opposite Gold House,
Tel: 0302-302242

MADINA
Net 2 Building
Zongo Junction
Tel: 0302-521145/6

SUNYANI
1st Floor, Emmanuel Otoo
Building, Civic Centre, Sunyani
Tel: 030520-26611

KUMASI
Cocobod Jubilee House
P.O. Box 267, Kumasi
Tel: 03220-20702
Fax No.03220-20702

TAKORADI
Liberation Road
P.O. Box 1300, Takoradi
Tel: 03120-21121

TEMA
Vertical Plaza, Community 6
P.O. Box 2446, Tema
Tel: 0303-203798

CAPE COAST
Opposite Mfantsipim Sch. Gate
Kotokuraba, 2nd Floor
P.O. Box CC 381,
[Tel:03321-31316](tel:03321-31316), 36045
Fax No. 03321-31316

TAMALE
2nd Floor Quality first building
Opposite Main Taxi Rank
P.O. Box TL.2565
Tamale
Tel: 03720-26348, 27162

4. PARTICULARS OF MOTOR VEHICLE CONCERNED:

- a. Registration No.....Make.....Model.....Year of Make.....
Sum Insured.....
- b. Is the vehicle the subject of a hire purchase or loan agreement? Yes/No.....
If yes state name of finance company or lending organization.....
- c. If claim is under a Motor Trade Policy give name and address or owner of vehicle.....
- d. State fully the purpose for which the vehicle was being used. (It is not sufficient to state "Business" or "Private").....
- e. Was the vehicle being used with your consent? Yes/No.....
- f. Do you hold more than one Policy indemnifying you in respect of this accident? Yes/No

5. PARTICULARS OF PERSON DRIVING AT TIME OF ACCIDENT:

- a. Full Name.....Address.....
Age..... Occupation: Telephone No:
Driver's Licence No.....Date of Issue.....
REF #.....
For what group of vehicles has the licence been issued.....
- b. Has the driver ever been convicted of any motoring offence? Yes/No
If yes give details.....
- c. State whether the person driving at the time of accident was: (A) The Owner
(B) An employee (c) Relative or Friend?
If an employee, how long has he been in your employment as a driver?
.....
- d. If owner was not driving state whether the person driving owns a vehicle himself? Yes/No
If yes state name and address of the Insurer of the person driving and number of Policy held by him/her.....

6. CIRCUMSTANCE OF ACCIDENT:

- a. Date and time.....20..... ata.m/p.m
- b. Exact location of incident.....
- c. Speed of vehicle.....
- d. If after lighting up time what lights were lit on your vehicle
- e. How many persons were in your vehicle at the time of the accident.....
- f. If you were not in the vehicle, when was accident reported to you
- g. Give full description of how the accident happened?

(Use reverse of form if more space required)

- h. In your opinion was the accident caused by your driver? If not, by whom.....
- i. Damage to your vehicle.....
-
-
-
- j. Where can the vehicle be seen?.....
- k. Name and address of nearest Repairers.....

7. THIRD PARTIES INVOLVED IN ACCIDENT:

Name and address of persons injured and the extent of their injuries:

- a. Injured persons in your vehicle.....
- 1..... 2.....
- 3..... 4.....

- b. Injured persons in the other vehicle.....
- 1..... 2.....
- 3..... 4.....

Injured Pedestrians.....

- c. State details of other vehicles involved: Registration No..... Make.....
 Model.....
 State name and address of the driver of this vehicle.....
 State name and address of the owner of this vehicle.....
 State name and address of Insurer of this vehicle and policy number.....

- d. Details of damage to this vehicle.....
 Has any claim been made upon you? Yes/No If yes, state particular below and note that any letter or communication received by you must be forwarded immediately unanswered, to this Company.....

- 8. a. Has any person involved in the accident been given a notice of intended prosecutions by the Police? Yes/ No.....
 If yes, state details.....

- b. Witnesses:
 1.....
 2.....
 3.....

- c. State names and addresses of any independent witnesses:
 1.....
 2.....
 3.....

- 9. a. Was the accident reported to the Police? Yes/No If yes, state date reported and at which Police Station.....
- b. Name Police Officer who took particulars.....

I / We declare that the above statement is true in all respects to the best of my/our knowledge and belief and I/We hereby leave in the hands of the Company in accordance with the Conditions of the Policy the conduct of all claims, and litigation arising out of this accident and to which the Policy applies, to deal with, to prosecute and/or settle as they think fit without further reference to me/us and I/We undertake to give all such information and assistance as the Company may require.

Driver's Signature.....

Date

Insured's Signature

SKETCH

Please make a sketch showing position of Vehicles and persons concerned both before and after the Accident, and showing the directions in which they were travelling.

POSITION BEFORE ACCIDENT

POSITION AFTER ACCIDENT
