

AUTOMOBILE ACCIDENT REPORT

IBC CLAIM FORM

CLAIM NUMBER

INSURER

AGENT OR BROKER

POLICY HOLDER

NAME OF INSURED

BRAMPTON TRANSIT

RESIDENCE PHONE

BUSINESS PHONE **905 874 2750**

ADDRESS

POSTAL CODE

BUSINESS ADDRESS

SAME

POSTAL C

VEHICLE

REGISTERED OWNER

CORP. OF THE CITY OF BRAMPTON

ADDRESS

2 WELLINGTON STREET WEST

BUS#

BRAMPTON, ONT. L6Y 4R2

DESCRIBE DAMAGE.

DRIVER

NAME OF DRIVER

AGE

STATE ANY PHYSICAL DISABILITIES

HOW LONG DRIVING

ADDRESS

BUSINESS ADDRESS

SAME AS ABOVE.

RESIDENCE PHONE - ()

BUSINESS PHONE - **(905) 874-2750**

DRIVER'S LICENCE NO.

PROVINCE OF ISSUE

PREVIOUS ACCIDENTS OR CONVICTIONS

DATE OF ACCIDENT
DAY MONTH YEAR

TIME

A.M.
P.M.

DAYLIGHT DUSK

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

YES
 NO

WHO WAS RESPONSIBLE FOR THE ACCIDENT - REASON

DAMAGE TO PROPERTY OF OTHERS

NAME

PHONE

NAME

PHONE

ADDRESS

ADDRESS

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

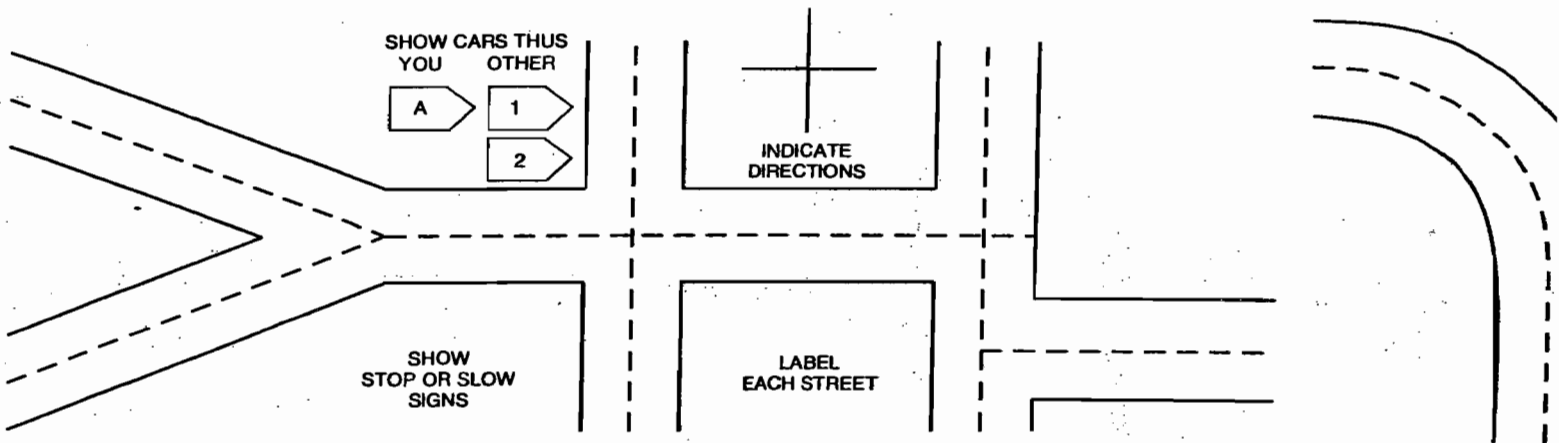
| PERSONS INJURED | NAME | AGE | ADDRESS | PHONE | NATURE OF INJURIES | HOSP |
|-----------------|------|-----|---------|-------|--------------------|------|
| | | | | | | |

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 POLICY HOLDER:

| | |
|---|---------------------------------------|
| 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 POLICY HOLDER: |