

Please complete all applicable fields. Please ensure they are legible.

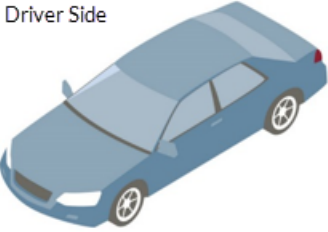
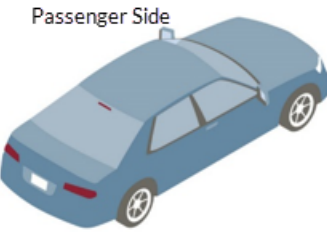
Claim Information

Driver's Full Name:		Driver's Licence Number:	Claim Number:
City/Town (nearest to):		Accident Date:	Time of Loss: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Did police attend the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No Police Report Number:		Did an ambulance attend the scene? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you consume any drugs or alcohol in the 12 hours before the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what did you consume and how much did you consume?			

Collision Details Scene Photos Dash Cam Footage (Email to adj with claim #)

Street/road you were traveling on:		What lane were you traveling in? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Center <input type="checkbox"/> Other	
In what direction was your vehicle traveling? <input type="checkbox"/> North <input type="checkbox"/> South <input type="checkbox"/> Unknown <input type="checkbox"/> East <input type="checkbox"/> West		At the time of the collision, what was the motion of your vehicle? <input type="checkbox"/> Accelerating <input type="checkbox"/> Stopped <input type="checkbox"/> Turning <input type="checkbox"/> Braking <input type="checkbox"/> Reversing <input type="checkbox"/> Parked <input type="checkbox"/> Changing Lanes	
Were there any traffic control devices for your vehicle's direction of travel? <input type="checkbox"/> Traffic Light <input type="checkbox"/> Stop Sign <input type="checkbox"/> Unknown <input type="checkbox"/> Yield <input type="checkbox"/> None <input type="checkbox"/> Other		If you selected traffic light, indicate the type and colour: <input type="checkbox"/> Solid <input type="checkbox"/> Green <input type="checkbox"/> Flashing <input type="checkbox"/> Amber <input type="checkbox"/> Arrow <input type="checkbox"/> Red <input type="checkbox"/> Unknown	
What did your vehicle collide with?			
What was your approximate distance from the object when first seen?			

Damage Information

<p>Identify your vehicle damage.</p> <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <div style="text-align: center;"> <p>Driver Side</p>  </div> <div style="text-align: center;"> <p>Passenger Side</p>  </div> </div>	<p>Comments:</p>
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Loss Details Information

Use the space below to describe the collision in detail in your own words. If more space is required, please add your own page(s). If writing, please ensure it is legible.





Accident Diagram

Draw a diagram below showing the position of all vehicles and their direction of travel. Label streets and all objects. An area for a legend has been provided.

Scan your accident diagram and save the image. To upload a file, click the image box below.



LEGEND

 Your Vehicle	 Stop Sign	 Traffic Light	 Pedestrian
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I HAVE READ THIS REPORT AND THE FACTS AS STATED ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

DRIVER'S SIGNATURE

DATE

CO-SIGNATURE (DRIVER UNDER 18 YEARS OF AGE)

DATE

If you are submitting the Driver's Report via email, an electronic signature will be accepted.
Please save the form as a PDF and send as an attachment to your adjuster.

Review the Driver's Report and ensure that all the below information is included. If the section is not relevant to the loss, check "N/A" for not applicable.

Complete	N/A	Form Section
Page 1		
<input type="checkbox"/>	<input type="checkbox"/>	Claim Information: <i>Fill out in full</i>
<input type="checkbox"/>	<input type="checkbox"/>	Collision Details: <i>Fill out as accurately as possible, if you are unsure about an area indicate unknown. Include any photos if available.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Damage Information: <i>Indicate the location of the damage on your vehicle.</i>
Page 2		
<input type="checkbox"/>	<input type="checkbox"/>	Loss Details Information: <i>Provide a description of the accident in as much detail as possible.</i>
Page 3		
<input type="checkbox"/>	<input type="checkbox"/>	Accident Diagram: <i>Provide a diagram of the accident including the intersection, any lights, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	Signature and Date: <i>Review the report in full, then sign and date the report.</i>