Chung Kuo Insurance Company, Limited

ALPHA INSURERS
General Agent
123 Archbishop Flores St.
Hagatna, Guam 96910
Tel: (671) 477-8701/2

AUTOMOBILE ACCIDENT REPORT

REPORT ALL ACCIDENTS OR LOSSES IMMEDIATELY,
especially if anyone was injured, followed by mail report.
PLEASE COMPLETE ALL SECTIONS.

Reporting Only: YES ☐ NO ☐
Policy Number: ______
Policy Period: ______
Prem. Balance: ______ Initial & Date: ______
Deductible Amt: ______ Initial & Date: ______

1. POLICY HOLDER AND DRIVER

Policy Holder(s) / Registered Owner (s): ______ SSN: ______

Employer/Department & Title: ______ E-mail Address: ______

Physical Home Address: ______ Home: ______ Cell: ______

Mailing Address: ______ Work: ______ Ext. ______

Driver's Name: ______ Relationship to Owner: ______

Physical Home Address: ______ Phone: ______

Mailing Address: ______ Driver's Age: ______

Driver's License No. OR Permit No. ______ Years of driving experience: ______

Date Issued: ______ Will Expire: ______ Who authorized him/her to drive? ______

Name occupants of Policyholder's car: ______ How often do you drive? ______

2. POLICYHOLDER'S AUTOMOBILE

License Plate No. ______ Year: ______ Make: ______ Model: ______

Body Type: ______ VIN # (located on Registration): ______

Name or Lien Holder (Financial Institution of Vehicle Loan): ______

3. DATE AND PLACE

Date: ______ Time: ______

Where did accident occur? ______ City: ______ State: ______

Personal or Business Use: ______ Where is vehicle at now? ______

Was accident reported to your Insurance? ______ If yes, indicate firm: ______

4. WITNESSES/THIS IS IMPORTANT

4. WITNESSES/THIS IS IMPORTANT - The names and addresses of all witnesses, bystanders or people in the immediate vicinity, who may have seen the accident or heard any statement made, should be secured.

Name: ______ Contact No. ______ Relationship ______

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5. THE ACCIDENT/GIVE COMPLETE DETAILS

Direction my automobile was going: ______ What side of street?: ______

How fast?: ______ Speed Limit: ______ Were your headlights on?: ______ Signals? ______

Condition of Street: ______

If object collided with was moving, in what direction was it going? ______

How fast? ______ What side of street?: ______ Any signals given?: ______

If an automobile, were lights on?: ______ Were traffic controls present?: ______

Was either driver violating traffic regulation?: ______

Was accident investigated by police?: ______ Who?: ______ Was car towed?: ______

Where towed to: ______ Was anyone charged?: ______

6. DAMAGE TO PROPERTY OF OTHERS (NOT YOUR CAR)

Name and address of owner of damaged auto or other property: ______________________

Name of other party's insurance carrier?: ______________________

Year: ________ Make: ______________ Model: ______________ Body Type: ______________

Give the nature and extent of damage to auto or other property: ______________________

____

______________________________ Estimated Repair Cost: $ __________

Name of driver of other car: ______________________ Address: ______________________

Occupants of other car: ______________________ Address: ______________________

______________________ Address: ______________________

Where can investigator see other car? ______________________

7. PERSONAL INJURIES

	Injured's Name	Addresses (Business & Home)	Injuries
1.			
2.			
3.			
4.			

Name and address of Doctor called: ______________________

Where was injured person taken?: ______________________

Where was injured person at time of accident?: ______________________

8. STATE FULL DETAILS OF HOW ACCIDENT HAPPENED

____

Assisted By: ______________________ Verified & Confirmed By: ______________________

Date: ______________________ Date: ______________________

9. DIAGRAM - Use diagram to show and position of all automobiles, vehicles, injured person, stop signs and other objects. Use arrows (↙) to show direction of moving objects. Give Names of Streets. Mark X where collision occurred.

BEFORE ACCIDENT	AFTER ACCIDENT

IMPORTANT!: Is claim being made against you? YES ☐ NO ☐ Do you anticipate a claim being made? YES ☐ NO ☐

Are you making claim against other party? YES ☐ NO ☐

Are you filing claim against your policy? YES ☐ If yes, please intial & date: ____________________

NO ☐ If no, please initial & date: ____________________

THIS SECTION APPLIES IF YOU HAVE STATED "NO" IN RESPONSE TO FILING A CLAIM AGAINST YOUR POLICY AND WISH TO CHANGE YOUR DECISION FOR THE DATE OF LOSS REPORTED.

I wish to file a claim on this said date, ____________________ for the date of loss noted above, due to the reasons stated below: ____

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If the facts were such that you would be held solely negligent and therefore liable for the damage, we should pay it.
If you were not solely negligent and if the accident was partly due to the negligence of the other party, you would not have to pay, and the Company should not pay on your behalf. Please give us as impartial an opinion as possible on this point.
In my opinion, I am ☐ / am not ☐ properly liable for the damage.

CERTIFICATE I certify that the foregoing is true and correct to the best of my knowledge and belief.

Policyholder's Name & Signature: ____________________ Date: ____________

Driver's Name & Signature: ____________________ Date: ____________