

Travelers Indemnity Company  
Policy No. H-810-OT392169-IND-26  
**DRIVER'S STATEMENT OF ACCIDENT**

**INSTRUCTIONS:** Please complete and return this with an itemized estimate of damage from a reliable garage of your choice. Please include a copy of the Police Report as well.

What is your name \_\_\_\_\_

317 East Church Street, Elmira, NY 14901

Year & Make of Vehicle \_\_\_\_\_ Type \_\_\_\_\_ Plate \_\_\_\_\_

VIN# \_\_\_\_\_

Owned by City of Elmira, New York Address 317 East Church Street, Elmira, NY 14901

Driven by \_\_\_\_\_ Address 317 East Church Street, Elmira, NY 14901

Age of Driver \_\_\_\_\_ Date of Birth \_\_\_\_\_ Drivers Lic. #. \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_ a.m. p.m. dark/light Weather? \_\_\_\_\_

Place of Accident: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Were Police Notified? Yes { } No { } What Station? \_\_\_\_\_

Was any driver given a ticket or arrested? You? Yes { } No { } Other Driver? Yes { } No { }

Charges? \_\_\_\_\_ Date of Hearing \_\_\_\_\_ Place \_\_\_\_\_

**Other Vehicle** Year & Make \_\_\_\_\_ Type \_\_\_\_\_ Lic. Plate \_\_\_\_\_

(if more than

one vehicle

use other side)

Owned by \_\_\_\_\_ Address \_\_\_\_\_

Driven by \_\_\_\_\_ Address \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

**Accident Facts:** Direction you were traveling \_\_\_\_\_ Street \_\_\_\_\_ Speed \_\_\_\_\_

Direction other car traveling \_\_\_\_\_ Street \_\_\_\_\_ Speed \_\_\_\_\_

Speed limit at point of accident \_\_\_\_\_ Any view obstructions? \_\_\_\_\_ If yes, explain \_\_\_\_\_

Traffic controls? Yes { } No { } Type \_\_\_\_\_

Any skid marks? Your car? Yes { } No { } How many feet \_\_\_\_\_

Other car? Yes { } No { } How many feet \_\_\_\_\_

What signal did you give? \_\_\_\_\_ Other car? \_\_\_\_\_

Were all your lights on? Yes { } No { } Other car? Yes { } No { }

Explain \_\_\_\_\_  
\_\_\_\_\_

Any statement made by you after the accident? \_\_\_\_\_  
\_\_\_\_\_

Any statement made by other party? \_\_\_\_\_

How far, in feet, was the other car from the point of impact, when you first saw it? \_\_\_\_\_

How far, in feet, was your car from the point of impact at that time? \_\_\_\_\_

Point of contact of vehicles: Yours \_\_\_\_\_ Others(s) \_\_\_\_\_

Was anyone injured? \_\_\_\_\_ If yes, please list names, addresses, ages, and a brief description of injury and treating doctor's name and address.

NAME	ADDRESS	AGE	INJURY	TREATING PHYSICIAN

Names and Addresses of any occupants to your vehicle  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Names and addresses of all other witnesses to accident  
\_\_\_\_\_  
\_\_\_\_\_

Are you making a claim for damages as a result of this accident? \_\_\_\_\_

If a replacement rental vehicle is necessary, please state reason \_\_\_\_\_

Has your car been repaired? Yes { } No { } In what amount? \_\_\_\_\_

What is the total amount of your claim (Please itemize – attach estimate) \_\_\_\_\_  
\_\_\_\_\_

Where can the car be seen? \_\_\_\_\_

Brief description of accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.”

Witness to signature \_\_\_\_\_ Signature \_\_\_\_\_

**Reviewed by:**

Fleet Supervisor: \_\_\_\_\_ (signature)

Department Head: \_\_\_\_\_ (signature)

**DIAGRAM OF ACCIDENT**