

IMPORTANT—PLEASE READ THIS CAREFULLY

Directions for use of the European Accident Statement

GENERAL NOTES

THE OBJECT OF THIS FORM IS TO GET A STATEMENT OF THE FACTS OF THE ACCIDENT AGREED BY EACH DRIVER.

The Continental driver will also have a similar form in his own language and it does not matter which one is completed, BUT you must ensure that you keep either the original or the copy of the completed form to send to your insurer.

(e.g. a Frenchman may fill in his part of his own form in French, leaving you to complete your part of his form in English—you will know what the questions mean by looking at your own form).

INSTRUCTIONS

AT THE SCENE OF THE ACCIDENT

1. Get details of all witnesses before they leave.
Complete question 5.
2. Preferably using a ballpoint pen, complete fully either the blue or the yellow part of the Agreed Statement of Facts (you will need to refer to your insurance certificate, green card and driving licence).
3. When you are satisfied with the accuracy of the statement, sign it and have it signed by the other driver (15).
4. Don't forget to—
 - (a) mark clearly under (10) the point of initial impact.
 - (b) put a cross (X) in each appropriate square on your side of (12) and state the total number of spaces marked with a cross.
 - (c) draw a plan of the accident location (13) showing all the information indicated.

UNDER NO CIRCUMSTANCES ALTER ANYTHING ON THE AGREED STATEMENT OF FACTS AFTER COMPLETION

WHEN YOU RETURN HOME

1. **FULLY COMPLETE the Motor Accident Report on the back of the English version of the Agreed Statement of Facts.**
2. **Send the completed Agreed Statement of Facts and Motor Accident Report immediately to your Insurer.**

SPECIAL NOTE

This form may be used even if no other vehicle is involved, for example: own damage, theft, fire, injury to pedestrian. etc.

KEEP THIS FORM (AND A BALLPOINT PEN) IN YOUR CAR

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**European
Accident Statement**

don't get angry

be polite

keep calm

see directions for use

ACCIDENT STATEMENT

Sheet 1/2

1. Date of accident _____ Time _____	2. Locality : _____ Place : Country :	3. Injury(ies) even if slight no <input type="checkbox"/> yes <input type="checkbox"/>
----------------------------------------------------	----------------------------------------------------------------	--------------------------------------------------------------------------------------------------

4. Material damage
other than to vehicles A and B objects other than vehicles
no yes no yes

5. Witnesses : names, addresses, tel.:

.....

.....

VEHICLE A

6. Insured/policyholder (see insurance certificate)
NAME
First name
Address
Postal code: Country:

7. Vehicle

MOTOR	TRAILER
Make, type	
Registration N°	Registration N°
Country of registration	Country of registration

8. Insurance company (see insurance certificate)
NAME
Policy N°
Green Card N°
Insurance Certificate
or Green Card valid from: to:

9. Driver (see driving licence)
NAME
First name
Date of birth:
Address:
..... Country:

10. Indicate the point of initial impact to vehicle A by an arrow →

11. Visible damage to vehicle A: _____

.....

.....

14. My remarks:

.....

.....

12. CIRCUMSTANCES

Put a cross in each of the relevant boxes to help explain the drawing
**delete where appropriate*

A		B
<input type="checkbox"/> 1 *parked/stopped <input type="checkbox"/> 2 *leaving a parking place/ opening the door <input type="checkbox"/> 3 entering a parking place <input type="checkbox"/> 4 emerging from a car park, from private ground, from track <input type="checkbox"/> 5 entering a car park, private ground, a track <input type="checkbox"/> 6 entering a roundabout <input type="checkbox"/> 7 circulating a roundabout <input type="checkbox"/> 8 striking the rear of the other vehicle while going in the same direction and in the same lane <input type="checkbox"/> 9 going in the same direction but in a different lane <input type="checkbox"/> 10 changing lanes <input type="checkbox"/> 11 overtaking <input type="checkbox"/> 12 turning to the right <input type="checkbox"/> 13 turning to the left <input type="checkbox"/> 14 reversing <input type="checkbox"/> 15 encroaching on a lane reserved for circulation in the opposite direction <input type="checkbox"/> 16 coming from the right (at road junctions) <input type="checkbox"/> 17 had not observed a right of way sign or a red light <input type="checkbox"/> ← state number of boxes marked with a cross → <input type="checkbox"/>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17	

Must be signed by both drivers
Does not constitute an admission of liability, but a summary of identities and of the facts which will speed up the settlement of claims

13. Sketch of accident when impact occurred **13.**

Indicate: 1, the layout of the road - 2, by arrows the direction of the vehicles A, B - 3, their position at the time of impact - 4, the road signs - 5, names of the streets or roads

VEHICLE B

6. Insured/policyholder (see insurance certificate)
NAME
First name
Address
Postal code: Country:

7. Vehicle

MOTOR	TRAILER
Make, type	
Registration N°	Registration N°
Country of registration	Country of registration

8. Insurance company (see insurance certificate)
NAME
Policy N°
Green Card N°
Insurance Certificate
or Green Card valid from: to:

9. Driver (see driving licence)
NAME
First name
Date of birth:
Address:
..... Country:

10. Indicate the point of initial impact to vehicle B by an arrow →

11. Visible damage to vehicle B: _____

.....

.....

14. My remarks:

.....

.....

15. Signatures of the drivers **15.**

.....

.....

A

B

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MOTOR ACCIDENT REPORT

To be completed by the Insured and sent immediately to his Insurers

(Use a separate sheet of paper where necessary)

Insured	1 Occupation (if more than one state all) _____					
	2 Make/Model/Type	C.C.	If commercial vehicle state carrying capacity and g.p.w.	Date of first registration as new	Registration mark	
Insured Vehicle	Please give/confirm instructions on my/our behalf (where appropriate) for the repairs					
	3 Are you the Owner?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, state Owner's name and address _____		
	4 Exact purpose for which vehicle was being used at time of accident	_____				
	5 Is the vehicle still in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, state where it is at present _____		
	Tel. No. _____					
6 Name and address of Finance Company (if any)	_____					
Driver or Person in charge of Vehicle	7 Date of Birth	Occupation (if more than one, state all)	Date driving test passed	Was he driving with your permission?	Was he your employee?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	8 Give details of any impairment of sight or hearing and of any other disability _____					
(If the Insured complete this section as appropriate)	9 Full details of all driving convictions including pending prosecutions					
	Date	Offence	Penalty			
Injured Persons	10 Name(s), Address(es) and approximate Age(s)		Injuries Sustained	If Vehicle Occupants state in which vehicle	Were seat belts being worn?	
Damage to Property & Vehicles	11 Owner(s) Name(s) and Address(es)		Details of Vehicle or Property	Nature of Damage	Insurer's Name and Address (if known)	
Police Action	12 Was the accident reported to Police		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	If yes, give station and P.C.'s name and number _____					
Accident Details	13 Was warning of prosecution given?		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
	If yes against whom? _____					
	14 Weather conditions _____					
	15 Speed of vehicles		A <input type="text"/>	B <input type="text"/>		
	16 What warnings were given by driver or other party? _____					
	17 Were street lights illuminated?		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
18 What lights were displayed on your vehicle/the other vehicle(s)? _____						
19 If your vehicle is commercial state weight of load carried at time of accident _____						
20 State how accident happened, indicating width of roads, speed limits, etc. _____						
Declaration	I/We declare the foregoing particulars are true in every respect					
	Insured's Signature _____				Date _____	