



Vehicle Accident Report Kit

Keep this kit in your vehicle.

Contains Instructions and Forms:

- Driver's Report of Motor Vehicle Accident
- Traffic Accident Exchange Information
- Witness Information Cards

To learn more about managing your risk and increasing efficiency, visit [cna.com](https://www.cna.com).



What To Do After an Accident

- 1 Take immediate action** to prevent further damage at the scene of the accident.
 - a. Pull onto shoulder or side of the road.
 - b. Place warning signals promptly and properly.
- 2 Call police.** If someone is injured, request medical assistance. If fire is involved, request fire department aid.
- 3 Exchange *Traffic Accident Exchange Information form*** with other driver(s). The forms are enclosed.
- 4 Take photographs, videos and panoramas of the scene of the accident.** Where possible, include images of the weather and road condition, vehicle or other physical damage, neighboring businesses, and traffic control devices. Any other pertinent information, such as potential witness vehicles and tag numbers, should also be photographed or documented.
- 5 Secure names and addresses** of all witnesses to the accident using the enclosed information cards.
- 6 Be courteous.** Answer police questions. **Give identifying information** to the other party involved, but make no comments about assuming responsibility.
- 7 Complete both sides of the *Driver's Report of Motor Vehicle Accident form*.** You will need this information later for state and insurance reports.
- 8** As soon as possible, **report the accident** to your insurance company and your employer. If you are a CNA insured, **contact your agent** as well.

Driver's Report of Motor Vehicle Accident

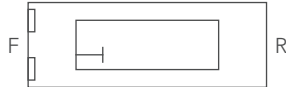
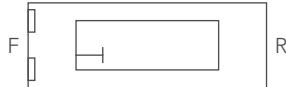
1. Where Accident Occurred				2. When Accident Occurred						
County/District _____		City/Municipality _____		Month _____	Day _____	Year _____				
Road or Street on which Accident Occurred _____ <small>(Highway Number, if not highway number identify road by name)</small>				Hour _____	<input type="checkbox"/> AM <input type="checkbox"/> PM					
At Intersection with _____ <small>(Number or Name of Intersecting Highway or Street)</small>				Number of Vehicles Involved in Accident _____						
If not at Intersection _____ or _____ <small>Feet Miles N S E W of (Circle one) (Nearest Highway, Street, Bridge or other Landmark)</small>				Did police officer investigate accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						
				Was traffic citation issued to Driver #1? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. Vehicle Number 1 – Your Vehicle				<div style="text-align: center;">Circle Point of Contact #1</div>  <div style="text-align: center;">Circle Point of Contact #2</div> 						
Company Name _____		Address _____								
Driver Name (Last, First, Middle) _____		Vehicle License Number – State, Year _____								
Vehicle Make _____ Year _____ Model, Type _____		Vehicle Identification Number _____								
4. Driver Number 2 – Other Driver – or Pedestrian										
<input type="checkbox"/> Driver's Name (Last, First, Middle) _____			Birth (Mo/Day/Yr) _____	Driver's License Number _____	State _____	Gender _____				
<input type="checkbox"/> Pedestrian _____										
Was traffic citation issued to Driver #1? <input type="checkbox"/> Yes <input type="checkbox"/> No			City _____	County of Residence _____		State _____				
Was traffic citation issued to Driver #2? <input type="checkbox"/> Yes <input type="checkbox"/> No										
5. Vehicle Number 2 – Other Vehicle										
Owner Name _____			Address _____							
Vehicle Make _____ Year _____ Model, Type _____			Vehicle License Number – State, Year _____							
Was traffic citation issued to Driver #1? <input type="checkbox"/> Yes <input type="checkbox"/> No			Vehicle Identification Number _____							
Was traffic citation issued to Driver #2? <input type="checkbox"/> Yes <input type="checkbox"/> No										
6. List Persons Killed or Injured				Age	Sex	Veh. No	Seating	Seat Belts	Ejection	Injury
Name _____			Address _____							
Describe Injuries _____										
Name _____			Address _____							
Describe Injuries _____										
Describe Damage to Property other than Motor Vehicles _____				Owner's Name _____						
				Owner's Address _____						

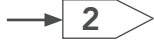
Diagram What Happened Instructions

Please use this Driver's Report to record what happened in your own words, while it is still fresh in your memory.

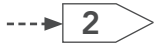
1. Follow dotted lines to draw outline of roadway at place of accident.
2. Number each vehicle and show direction of travel by arrow:



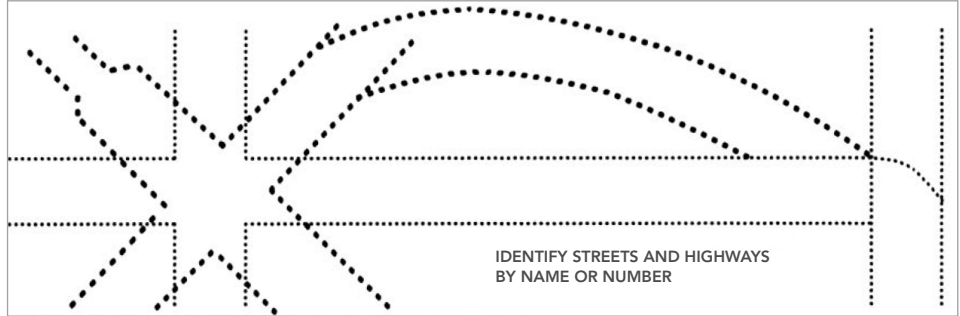
Use solid line to show path before accident:



Use dotted line after accident:



4. Show pedestrian by:
5. Show railroad by:
6. Show utility poles by:
7. Show motorcycle by:



Describe What Happened (Refer to vehicles by number):

Photographs and videos provide information useful to the investigation. Along with other pertinent information remember to take photographs/videos of the scene of the accident.

Traffic Accident Exchange Information

ON:				IN:		
Name or Number of Street or Highway				City/Municipality	County/District	State/Province
AT:						
Names of Intersecting Roads or Distance From Landmark				Hour	Day of Week	Date
Driver Print full name				Address	City/State	Phone
Owner Print full name				Address	City/State	Phone
Driver's License Number	State		Birth date Day/Mo/Year		Insurance Company	
Vehicle Make	License Number	State	Year	Color	Agent Name	Agent Phone
Parts of Vehicle Damaged					Agent Address	

ON:				IN:		
Name or Number of Street or Highway				City/Town	County	State
AT:						
Names of Intersecting Roads or Distance From Landmark				Hour	Day of Week	Date
Driver Print full name				Address	City/State	Phone
Owner Print full name				Address	City/State	Phone
Driver's License Number	State		Birth date Day/Mo/Year		Insurance Company	
Vehicle Make	License Number	State	Year	Color	Agent Name	Agent Phone
Parts of Vehicle Damaged					Agent Address	

Witness Information Cards



INFORMATION CARD

Your cooperation in filling out this card and giving it to the driver will enable us to handle this matter in fairness to all parties concerned.

Insured Name _____

Policy Number _____

Accident Location (Street/Intersection) _____

Date _____ Time _____ A.M. P.M.

Did you see the accident happen? _____ Yes No

Did you see anyone hurt? _____ Yes No

Were you riding in a vehicle involved? _____ Yes No

Name _____

Address _____

City/Municipality _____ State/Province _____

Phone (Work) _____ (Mobile) _____



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