|  |
| --- |
| **General Information** |
| Name of person reporting      | Telephone number      | For reporting only[ ]  Yes [ ]  No |
| Name of Broker      | Broker telephone number      | Broker fax number      |

|  |
| --- |
| **Insured’s Information** |
| Name and address of the Insured (including postal code)      | Business telephone (incl.ext.)      Ext.       |
| Cellular number      |
| Contact name      | Contact e-mail address      | Contact language spoken      |

|  |
| --- |
| **Policy Information** |
| Policy number      | Policy period (dd/mm/yyyy)From       To       | Certificate number (if applicable)      |
| Lienholder/Other Insurance      |
| Coverage (Type of policy form, limits, deductible)      |

|  |
| --- |
| **Accident Information** |
| Address where loss occurred      | Date of loss (dd/mm/yyyy)      | Time of loss       |
| Province or State/Country      |
| Please give description of loss      |
| No. of occupants in each vehicle including driverInsured’s       Third party’s       | Were seatbelts in use at time of loss?[ ]  Yes [ ]  No |
| Were citations/charges issued?[ ]  Yes [ ]  No | To whom?      | For what violation?      |
| Were the authorities contacted (police, fire, ambulance)?[ ]  Yes [ ]  No | Was a report number given?[ ]  Yes [ ]  No | If yes, list number      |
| If Police/Fire Department contacted, name of officer      | Division      | Badge number      |

|  |
| --- |
| **Insured’s Vehicle Information** |
| Driver’s name and address (including postal code)      | Home telephone      | Work telephone      | Date of birth (dd/mm/yyyy)      |
| Social Insurance No.      | Driver’s license no.      | Class      |
| Owner’s name and address      | Home telephone      | Work telephone      |
| Lessor’s name and address (if not owned)      | Home telephone      | Work telephone      |
| Vehicle year      | Make      | Model      | VIN number      | License plate number      | Province of issue      |
| Vehicle’s current location      | Area of damage      | Estimate ($)      | Telephone number      |
| Description of damage/include cargo if applicable      |
| Current status of vehicle[ ]  Drivable [ ]  Towed from accident scene | Were there injuries in this vehicle?[ ]  Yes [ ]  No |
| Name and address of injured party      | Telephone number      |
| Name and address of medical provider      |
| Doctor’s name      | Telephone number      | Medical attention given      |

|  |
| --- |
| **Claimant Information – Other Vehicle** |
| Driver’s name and address (including postal code)      | Home telephone      | Work telephone      | Date of birth (dd/mm/yyyy)      |
| Social Insurance No.      | Driver’s license no.      | Class      |
| Covered by other insurance?[ ]  Yes [ ]  No | If Yes, Company name      |
| Contact name      | Telephone number      |
| Owner’s name and address      | Home telephone      | Work telephone      |
| Lessor’s name and address (if not owned)      | Home telephone      | Work telephone      |
| Vehicle year      | Make      | Model      | VIN number      | License plate number      | Province of issue      |
| Vehicle’s current location      | Area of damage      | Estimate ($)      | Telephone number      |
| Description of damage/include cargo if applicable      |
| Current status of vehicle[ ]  Drivable [ ]  Towed from accident scene | Were there injuries in this vehicle?[ ]  Yes [ ]  No |
| Name and address of injured party      | Telephone number      |
| Name and address of medical provider      |
| Doctor’s name      | Telephone number      | Medical attention given      |

**Additional vehicles and claimants should be listed on an additional reporting form. Please attach.**

|  |
| --- |
| **Witness Information** |
| Name and address of a witness to the incident     3Telephone number where witness can be reached      |

|  |
| --- |
| **Additional Injury Information** |
| Name and address of additional injured party      |
| Nature of injury      | Body part      | Party’s telephone      | Location[ ]  Insured’s vehicle [ ]  Other vehicle [ ]  Pedestrian |
| Name and address of medical provider      |
| Doctor’s name      | Telephone number      |
| Anything related to the incident you would like to add      |

**Privacy Statement**: By submitting this information you are providing consent for the collection, use and disclosure of your personal information as may be necessary to access, investigate, and settle claims. Your personal information may be processed and stored by Zurich Insurance Company Ltd and its affiliates (collectively, “Zurich”) and authorized representatives, both in domestic and foreign jurisdictions outside Canada and is subject to applicable laws. Please contact the Zurich Privacy Officer if you require further additional information regarding the collection, use, disclosure, processing and storage of your personal information via email at privacy.zurich.canada@zurich.com or you can review our privacy statement at https://www.zurichcanada.com/en-ca/about-zurich/privacy-statement.

The above-named claimant may refuse to consent or withdraw their consent to the collection, storage, use or disclosure of personal information; however, the refusal to provide consent may result in Zurich being unable to offer and administer insurance coverage or prevent Zurich from being able to pay claim benefits.

Zurich is committed to protecting the privacy and confidentiality of information provided. Your file is secured in our offices or those of our administrator or agent. You may request to review the personal information it contains and make corrections by writing to: Privacy Officer, Zurich Insurance Company Ltd (Canadian Branch), 100 King Street West, Suite 5500, P.O. Box 290, Toronto, ON M5X 1C9

For the purpose of *the Insurance Companies Act* (Canada), this document was issued in the course of the Company’s insurance business in Canada.