



GEMINIA INSURANCE CO. LTD
 6TH FLOOR
 GEMINIA INSURANCE PLAZA
 KILIMANJARO AVENUE
 PO BOX 61316 CITY SQUARE
 NAIROBI 00200 KENYA
 TELEPHONE: 2782000
 FAX: 2782100
 EMAIL: info@gemina.co.ke

IMPORTANT NOTICE

1. No Liability is admitted by Issue of this form
2. Neither owner nor driver may admit fault or Liability for this Accident
3. Do not answer communications about this accident. Direct this to the Insurance Company for action.
4. All questions on this form must be answered.
5. Repairs must not be authorized without prior authority of the Insurance Company.

MOTOR ACCIDENT REPORT FORM

INSURED	Name				
	Business/Occupation				
	Address				
	Code				
	Town				
	Email Address				
	Tel. No. (Land Line)				
Tel. No. (Cell Phone)					
POLICY	Number				
	Expiry Date				
	Name of Hire Purchase or Finance Company				
VEHICLE	Make & Model				
	Reg. No. of Vehicle				
	Carrying Capacity				
	Reg. No. of Trailer				
	Carrying Capacity				
	HP/CC				
USE	Name and Address of Owner				
	State the exact purpose for which the vehicle was being used at the time of the accident				
COMMERCIAL VEHICLES	Description of goods being carried				
	Name and owner of goods				
	Was the trailer attached?				
	Weight of load on	(a) Vehicle		(b) Trailer(s)	
DRIVER	Name				
	Occupation				
	Date of Birth				
	Address				
	Code				
	Town				
	Email Address				
	Tel. No. (Cell Phone)				
	Is he/she employed by you?	Yes.	<input type="checkbox"/>	No.	<input type="checkbox"/>
	No of years in service				
	Was he/she driving with your permission?	Yes.	<input type="checkbox"/>	No.	<input type="checkbox"/>
	How long has he/she been driving motor vehicle?				
	Was he/she in any way to blame for the accident?				
	Did he/she admit liability?				
	Has he/she had any previous accidents?				
	If so, how many and approximate dates?				
	Has he/she any conviction for any offence in connection with any motor vehicle or any charges pending?				
	If so, give details including dates.				
	Does he hold a full or provisional licence to drive this vehicle? If full, state date when driving test passed and Number				
	Does he/she own a Motor Vehicle?				
If So, give name and address of					

	Insurer and Driver's Policy No.			
ACCIDENT	Date & Time	a.m/pm		
	Place			
	Type of Road surface			
	Visibility			
	Wet or Dry?			
	What lights were showing on your vehicle?			
	What warning did your driver give?			
	Estimated speed before accident			
	Weather conditions			
	Did police take particulars? If so, give Constable's number and station			
	To which Police station was the accident reported?			
	Attach copy Notice of intended prosecution if any			
PLAN OF ACCIDENT	Draw sketch (stating approximate measurements) showing position of vehicle(s) and person(s) concerned and the direction in which they were travelling. Also showing type and position of traffic signs, skid marks, pedestrian crossings and any other relevant information.			
STATEMENT BY DRIVER	Signature of Driver			
STATEMENT BY OWNER OR INSURED				
DAMAGE TO INSURED VEHICLE	State briefly apparent damage			
	(In all cases where your vehicle is damaged and you are entitled to claim under your policy, please send at once to the Company an estimate for repairs)			
	Repairer's Contacts	Name:		
		Address:		
		Tel. No.:		
		Email Address:		
Is the vehicle still in use?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
When and where can it be inspected?				
OTHER VEHICLES INVOLVED AND PROPERTY DAMAGED	Name and address of owner	Reg. No.	Name of Insurer	Other property damaged
PERSONS INJURED	Name and address	Relationship to the Insured	If Driver or Passenger Reg. No. of Vehicle	Apparent Injuries
INDEPENDENT	Name		Address	

WITNESSES		
PASSENGERS IN YOUR VEHICLE	Name	Address

(For Official Use Only)	Claim No.	
--------------------------------	------------------	--

I declare that these particulars are true and correct and undertake to forward immediately (and unanswered) any correspondence relating to this accident.

Date _____ Signature of Insured _____

DOWNLOAD