The Insurance Company Of The West Indies (Trinidad) Limited
13 Gray Street, St Clair, Port of Spain, Trinidad
Tel: (868) 625-1116-9

THIRD PARTY ACCIDENT/LOSS REPORT FORM

Claim No: _____

Name of Owner / Claimant:		Vehicle No.:
Address:		Make of Vehicle:
Profession / Occupation:		Phone No.:
Employer:	Address:	
Name of Insurance Company:		
Type of Coverage:	Policy No.:	Expiry Date:
Email (Wk):	(H):	Vat No.:

DRIVER

Name of Driver:		Date of Birth:
Address:		Phone No:
Profession / Occupation:		Permit No.:
Date of Issue:		Expiry Date.:
Does Driver Own a Vehicle:	Yes ☐ No ☐	Vehicle No.:

CLIENT / INSURED

Client's Name:	Vehicle No.:
Driver's Name & Address:	
Date of Accident / Loss:	Time:
Location of Accident / Loss:	
Address of Police Station:	Date Reported:
Name of Officer / Number:	

DETAILS OF ACCIDENT / LOSS

** Please do not exceed more than 250 words.

SKETCH OF ACCIDENT / LOSS

WITNESSES (IMPORTANT)

NAME	ADDRESS	PHONE NO.

INJURY TO PERSONS

NAME	AGE	ADDRESS	NATURE OF INJURIES

Signature of Claimant **Date**