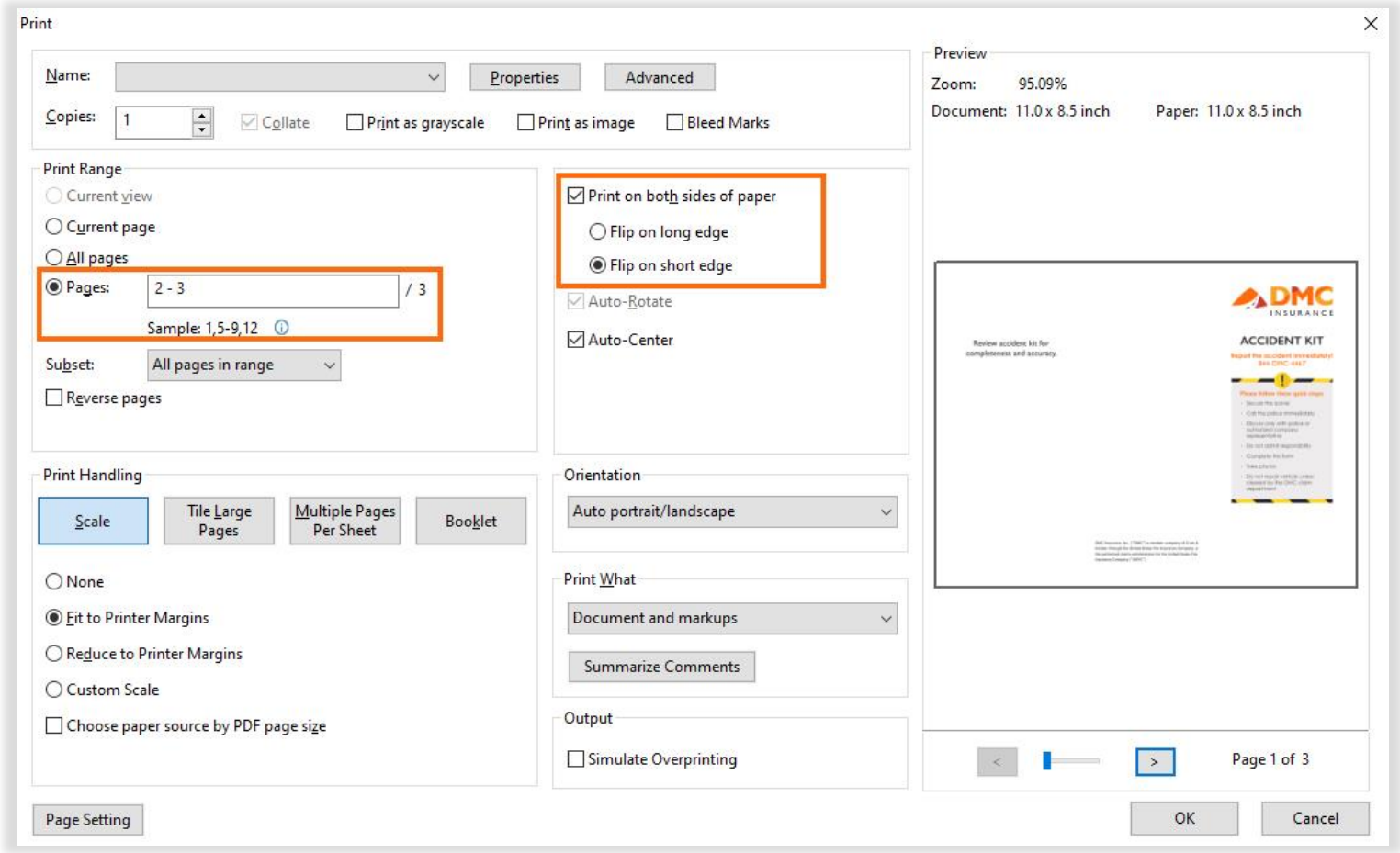
Accident Kit Printing Instructions:

1. Choose a custom print range of “Pages 2-3”.
2. Select “Print on both sides of paper”.
3. Choose “Flip on short edge”.

Note: This page should not print.



Review accident kit for completeness and accuracy.

DMC INSURANCE

ACCIDENT KIT

Report the accident immediately!
844-DMC-4467

Please follow these quick steps:

- Secure the scene
- Call the police immediately
- Discuss only with police or authorized company representative
- Do not admit responsibility
- Complete this form
- Take photos
- Do not repair vehicle unless cleared by the DMC claim department

The Accident

Date: _____ Time: _____AM/PM
Location: _____
City: _____ State: _____

Driver Information
Driver's Name: _____
Driver's License #:_____
Address: _____
City: _____ State: _____
Phone: _____

Equipment Information

Make: _____
Model: _____
Year: _____ Unit #: _____
VIN: _____
Damage: _____

Trailer Information
Loaded: _____Y/N
Cargo: _____
Cargo Damage: _____Y/N
Fuel Spill: _____Y/N
Towed: _____Y/N
If so, where? _____
VIN #: _____

Police Information

Did Police make a report? _____Y/N
Police Dept.: _____
Officer's Name: _____
Report #: _____
Was a citation issued? _____Y/N
Who was cited? _____
Citation: _____

Other Vehicle #1

Driver Name: _____
Driver's License #: _____
Address: _____
City: _____ State: _____
Phone: _____
DOB: _____ Injured: _____Y/N

Make: _____
Model: _____
VIN: _____
Plate #: _____
Insurance Co.: _____
Policy #: _____

# of Passengers: _____
Injuries: _____Y/N
Damage Description: _____
_____
Towed: _____Y/N

Injured Person

Name: _____
Address: _____
City: _____ State: _____
Phone: _____
Age: _____
Treated at scene: _____Y/N
Taken to medical facility: _____Y/N

Witness

Name: _____
Address: _____
City: _____ State: _____
Phone: _____
Age: _____ Occupation: _____
Email: _____

Other Vehicle #2

Driver Name: _____
Driver's License #: _____
Address: _____
City: _____ State: _____
Phone: _____
DOB: _____ Injured: _____Y/N

Make: _____
Model: _____
VIN: _____
Plate #: _____
Insurance Co.: _____
Policy #: _____

# of Passengers: _____
Injuries: _____Y/N
Damage Description: _____
_____
Towed: _____Y/N

Injured Person

Name: _____
Address: _____
City: _____ State: _____
Phone: _____
Age: _____
Treated at scene: _____Y/N
Taken to medical facility: _____Y/N

Witness

Name: _____
Address: _____
City: _____ State: _____
Phone: _____
Age: _____ Occupation: _____
Email: _____