

**THE PREMIER INSURANCE COMPANY OF MASSACHUSETTS
ACCIDENT WITNESS STATEMENT**

CLAIM NUMBER: _____ DATE OF ACCIDENT: _____

VEHICLE NO. 1: _____ OWNER'S NAME: _____

VEHICLE NO. 2: _____ OWNER'S NAME: _____

WHERE DID ACCIDENT OCCUR _____

WHEN (DATE & TIME) _____ AM/PM DID YOU SEE IT? YES _____ NO _____

WHERE WERE YOU _____ WERE YOU INJURED? YES _____ NO _____

WHAT DIRECTION WAS VEHICLE NO. 1 GOING _____ WHAT SPEED _____ MPH

WHAT DIRECTION WAS VEHICLE NO. 2 GOING _____ WHAT SPEED _____ MPH

DID EITHER DRIVER SOUND HORN _____ WHICH DRIVER: VEHICLE NO. 1 _____ VEHICLE NO. 2 _____

DID EITHER DRIVER GIVE HAND OR DIRECTIONAL LIGHT SIGNAL _____

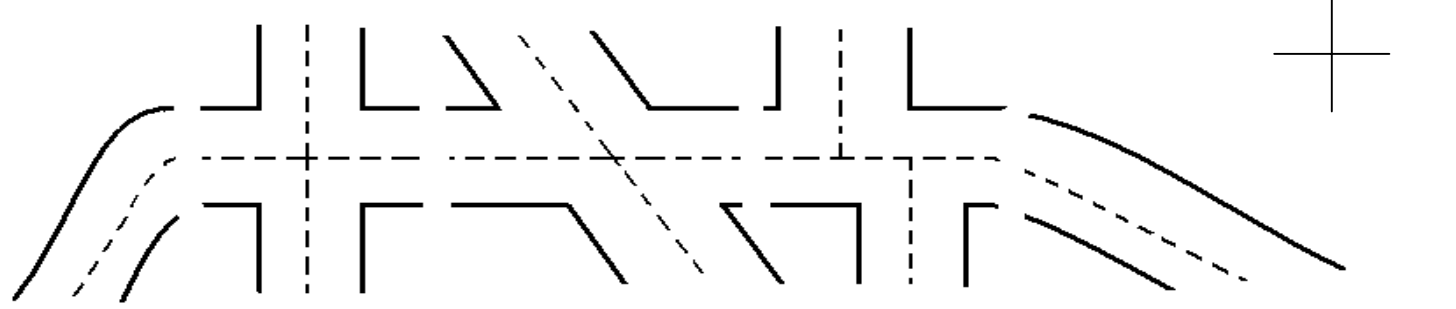
WHICH DRIVER: VEHICLE NO. 1 _____ VEHICLE NO. 2 _____

DESCRIBE IN DETAIL, AND STATE WHETHER OR NOT EITHER DRIVER DISOBEYED A STOP SIGN OR TRAFFIC LIGHT OR WAS ON THE WRONG SIDE OF THE STREET, OR WAS GUILTY OF ANY TRAFFIC VIOLATION: _____

DO YOU KNOW ANYONE ELSE WHO SAW THE ACCIDENT? (please give names and addresses of all such persons) _____

WHO DO YOU THINK WAS AT FAULT _____

SHOW HOW ACCIDENT OCCURRED BY USING THIS DIAGRAM



THIS SPACE IS FOR YOUR USE IF YOU WISH TO ADD ANYTHING TO THAT GIVEN ABOVE _____

YOUR NAME (PLEASE PRINT) _____ AGE _____ TELEPHONE NO. () _____

YOUR ADDRESS (NO. STREET, CITY, STATE, ZIP CODE) _____

DATE _____ SIGNATURE _____