GLOBE INSURANCE
Company of Jamaica Limited

KINGSTON: 19 Dominica Drive
Telephone: 926-3720
Fax: 929-2727

MONTEGO BAY: Lot B15,
Fairview II Shopping Centre
P.O. Box 170
Telephone: 935-6661
Fax: 929-5256

THIRD PARTY (GENERAL) ACCIDENT REPORT FORM

Branch _____ Policy No _____ Claim No _____

This form should be completed and returned to the Insurers immediately, whether a claim has been made on the Insured or not.

1. Name of Insured _____
   Address of Insured _____
   Business Address _____
   Telephone No. _____

2. Place of Accident _____
   Date of Accident _____ Time of Accident _____

3. If the accident occurred on premises occupied by the Insured and was due to a defect in th premises, who is responsible for maintenance and repair of the property?

4. Please explain how the accident occurred

5. Nature and extent of injury or damage

6. (a) Name of Injured Person _____ Age of Injured Person _____
   Addres of Injured Person _____
   (b) Name of owner of property damaged _____
   Address of owner of property damaged _____
   (c) Is he or she in your service? ◯ Yes ◯ No

7. State whether any claim has been made upon you, with details of amount, if known. If the claim is in writing please forward the communication to us unanswered.

8. When, and by whom was the accident reported to you

9.

Names and addresses of witnesses to accident	
Names	Addresses

10. Give the number of the policeman, if any, who took particulars.

I/We hereby declare that to the best of my/our knowledge and belief, the above statements are fully and truly made. I/We further declare that the statements above can be relied upon in the contemplation of litigation proceedings which may arise.

Date

Insured's Signature _____