



	OWN VEHICLE (No. 1)	Insurance number	OTHER VEHICLE (No. 2)	Number of vehicles involved			
DRIVER	Name		Name				
	Date of birth and ID code	Telephone (8 a.m.-4 p.m.)	Date of birth and ID code	Telephone (8 a.m.-4 p.m.)			
	Street address		Street address				
	Postal code and town or municipality		Postal code and town or municipality				
	Driving licence <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no	Date of issue of the first driving licence	Type of driving licence	Driving licence <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no			
POSSESSOR	Name		Name				
	Date of birth and ID code/Business ID	Telephone (8 a.m.-4 p.m.)	Date of birth and ID code/Business ID	Telephone (8 a.m.-4 p.m.)			
	Street address		Street address				
	Postal code and town or municipality		Postal code and town or municipality				
KEEPER	Name		Name				
	Date of birth and ID code	Telephone (8 a.m.-4 p.m.)	Date of birth and ID code	Telephone (8 a.m.-4 p.m.)			
	Registration number		Type (e.g. car)				
VEHICLE	Make and model		The first year of service				
	Motor third party liability insurer		Voluntary motor vehicle insurer				
	Leased vehicle <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no		Company car <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no		VATdeductible/repayable <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no		
	Was a trailer used? <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no		Registration number		Voluntary motor vehicle insurer		
TRAILER	Motor third party liability insurer		Voluntary motor vehicle insurer		Motor third party liability insurer		
	Motor third party liability insurer		Voluntary motor vehicle insurer		Motor third party liability insurer		
DAMAGE TO VEHICLE	Please darken the damaged parts. Damage inspection must be agreed on with the insurer before any repairs.		Please darken the damaged parts. Damage inspection must be agreed on with the insurer before any repairs.		Please darken the damaged parts. Damage inspection must be agreed on with the insurer before any repairs.		
BANKERS	To whom will the compensation be paid? (name)		To whom will the compensation be paid? (name)		To whom will the compensation be paid? (name)		
	Bankers (bank and full account number)		Bankers (bank and full account number)		Bankers (bank and full account number)		
BODILY INJURIES		IN OWN VEHICLE injured persons	dead persons	IN OTHER VEHICLES injured persons	dead persons	OUTSIDE THE VEHICLE injured persons	
PERSONS SUFFERING INJURIES	Name		Name		Name		
	Date of birth and ID code	Occupation	Date of birth and ID code	Occupation	Date of birth and ID code	Occupation	
	Street address		Street address		Street address		
	Postal code and town or municipality		Telephone (8 a.m.-4 p.m.)		Postal code and town or municipality		
	Telephone (8 a.m.-4 p.m.)		Postal code and town or municipality		Telephone (8 a.m.-4 p.m.)		
	The person suffering injuries was in the vehicle no. _____ <input type="checkbox"/> 1 driver <input type="checkbox"/> 2 front seat passenger <input type="checkbox"/> 3 passenger elsewhere <input type="checkbox"/> 4 not in the vehicle		The loss or damage occurred <input type="checkbox"/> 1 at work <input type="checkbox"/> 2 on one's way to or from work <input type="checkbox"/> 3 on one's way to or from school <input type="checkbox"/> 4 on leisure time Type of injuries <input type="checkbox"/> 1 minor injuries <input type="checkbox"/> 2 severe injuries <input type="checkbox"/> 3 dead		The person suffering injuries was in the vehicle no. _____ <input type="checkbox"/> 1 driver <input type="checkbox"/> 2 front seat passenger <input type="checkbox"/> 3 passenger elsewhere <input type="checkbox"/> 4 not in the vehicle		The loss or damage occurred <input type="checkbox"/> 1 at work <input type="checkbox"/> 2 on one's way to or from work <input type="checkbox"/> 3 on one's way to or from school <input type="checkbox"/> 4 on leisure time Type of injuries <input type="checkbox"/> 1 minor injuries <input type="checkbox"/> 2 severe injuries <input type="checkbox"/> 3 dead



Please use several forms if there are more than two vehicles involved or more than two persons with bodily injuries.

SKETCH OF THE ACCIDENT SCENE

Please draw and mark

- streets and roads with names
- position of the vehicles at the time of the accident
- driving directions (please mark carefully)
- traffic signs

Own vehicle 1  

Other vehicle 2  

HOW DID THE ACCIDENT OCCUR?

TIME, PLACE AND CIRCUMSTANCES

Date of accident _____ at _____ Day of the week _____ Town or municipality where the accident occurred _____

Exact place of accident (crossroads, street address, place name etc.) _____

Accident scene <input type="checkbox"/> 1 railway crossing <input type="checkbox"/> 2 junction of a private road or area <input type="checkbox"/> 3 priority junction <input type="checkbox"/> 4 equal junction <input type="checkbox"/> 5 bridge <input type="checkbox"/> 6 curve <input type="checkbox"/> 7 straight stretch <input type="checkbox"/> 8 parking area, square, yard, service station or comparable <input type="checkbox"/> 9 other area	Traffic lights <input type="checkbox"/> 1 no traffic lights <input type="checkbox"/> 2 traffic lights in operation <input type="checkbox"/> 3 traffic lights out of operation Speed limit at the scene of accident own vehicle, km/h _____ other vehicle, km/h _____ Speed before the accident own vehicle, km/h _____ other vehicle, km/h _____	Road number own vehicle _____ other vehicle _____ Type of street or road own vehicle: <input type="checkbox"/> 1 street or comparable, <input type="checkbox"/> 2 motorway, <input type="checkbox"/> 3 main road, <input type="checkbox"/> 4 other public road, <input type="checkbox"/> 5 private area, <input type="checkbox"/> 6 other road or area other vehicle: <input type="checkbox"/> 1 street or comparable, <input type="checkbox"/> 2 motorway, <input type="checkbox"/> 3 main road, <input type="checkbox"/> 4 other public road, <input type="checkbox"/> 5 private area, <input type="checkbox"/> 6 other road or area	Did the accident occur in a population centre? <input type="checkbox"/> 1 yes <input type="checkbox"/> 2 no Road surface <input type="checkbox"/> 1 clear and dry <input type="checkbox"/> 2 clear and wet <input type="checkbox"/> 3 snowy or icy Lighting <input type="checkbox"/> 1 daylight <input type="checkbox"/> 2 dawn or dusk <input type="checkbox"/> 3 dark, illuminated road <input type="checkbox"/> 4 dark, unlit road
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GUILT

Who do you think is responsible for the accident? _____ Does he/she admit his/her guilt?
 yes no

ALCOHOL

Were any of the persons involved in the accident under the influence of alcohol? no yes Who? _____ Was a blood test taken?
 no yes

POLICE INVESTIGATION

Were the police called to the scene? no yes Police district in charge of the case _____ Has a police investigation been carried out?
 no yes

WITNESSES

Name _____ Telephone (8 a.m.-4 p.m.) _____	Name _____ Telephone (8 a.m.-4 p.m.) _____
Street address _____	Street address _____
Postal code and town or municipality _____	Postal code and town or municipality _____

SIGNATURES

We disclose information on the loss or damage reported to LocalTapiola to the mutual claims register of the insurance companies. Simultaneously, we check the register for loss or damage reported to other insurance companies. We use the information only in connection with the claims handling to prevent crime against insurance companies.

Place and date _____	Place and date _____
Policyholder's signature and clarification of signature _____	Driver's signature _____