

# Accident Reporting Instructions

**All accidents must be reported to National Interstate. In the event of an accident, please follow these instructions:**

1. Stop immediately and call your Supervisor.
2. Protect the accident scene by placing appropriate warning devices and activating your hazard lights. If possible, post a person to warn oncoming traffic.
3. If possible, protect your equipment and cargo from further damage and/or theft. However, do NOT disturb the accident scene.
4. Be courteous, but do not sign anything or discuss the accident with anyone except the police, your supervisor and the National Interstate adjuster. Make sure you ask for verification of proper identification.
5. Do not admit responsibility or agree to pay for any damages or injuries of any kind.
6. Obtain witness statements using the enclosed **Witness Information Forms**.
7. Complete the **Accident Report Form** (see reverse side) and forward it to the National Interstate Claims department as soon as possible.
8. Take photos of the accident scene - this includes all vehicles involved, skid marks on roadway, any and all factors that contributed to the accident (road hazards), pre-existing damage to all involved vehicles and license plates of all vehicles including any witness vehicles.
9. If required by DOT guidelines or if your company policy requires a drug or alcohol test, complete the test post-accident. Confirm with your Supervisor when you report the accident if testing is required.

**Report an Accident – 24 Hours a Day**  
**800-316-9167**

**AN INSURANCE EXPERIENCE BUILT AROUND YOU.**



CLAIMS

1001 Kamokila Blvd. | Suite 201 | Kapolei, Hawaii 96707 | [natl.com](http://natl.com)

# Accident Report Form

## Enter Insured Information Here (VEH #1)

Name of Insured:		
Street Address:		
City:	State:	Zip Code:
Insurance Agency Name/Number:		
Contact Name:	Primary Phone:	
Insurance Policy Number:		
Date of Loss:	Driver Name:	
Location of Accident (street/city/state):		
Year/Make/VIN of Insured Vehicle:		

## Enter Other Vehicle Involved Information Here

VEH #2 Driver Name:		
Street Address:		
City:	State:	Zip Code:
Primary Phone:	Secondary Phone:	
Owner of Vehicle:		
License Plate Number:	Vehicle Registration State:	
Year/Make/VIN of Other Vehicle:		
Insurance Company Name:		
Insurance Policy Number:		
Passenger:	Their Phone Number:	
Passenger:	Their Phone Number:	
VEH #3 Driver Name:		
Street Address:		
City:	State:	Zip Code:
Primary Phone:	Secondary Phone:	
Owner of Vehicle:		
License Plate Number:	Vehicle Registration State:	
Year/Make/VIN of Other Vehicle:		
Insurance Company Name:		
Insurance Policy Number:		
Passenger:	Their Phone Number:	
Passenger:	Their Phone Number:	

## Enter Injured Person(s) Information Here

Name:	Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	Or Pedestrian: <input type="checkbox"/>	
Street Address:		
City:	State:	Zip Code:
Injuries:		

**\*Please use side two of the Witness Form to enter additional injured persons.\***

## Enter Police Report Information Here

Dept Name:	Officer Name:
Badge Number:	Phone Number:

## Enter Reporter Information Here

Reported By Name:	
Reported By Signature:	
Send Email to: <a href="mailto:hawaii.claims@natl.com">hawaii.claims@natl.com</a> <input type="checkbox"/>	Call: 800-316-9167 <input type="checkbox"/>

# Witness Information Form

Complete and Email to: [hawaii.claims@natl.com](mailto:hawaii.claims@natl.com)

Date of Accident: \_\_\_\_\_ Did you see the accident?  Yes  No

Was anyone hurt?  Yes  No If yes, who? \_\_\_\_\_

Location of the accident: \_\_\_\_\_

Were you a passenger in any of the vehicles involved?  Yes  No

If yes, please describe your injuries: \_\_\_\_\_

\_\_\_\_\_

Describe the accident and what you saw:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Your Contact Information

Your Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_



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# Injured Person(s) Information Form

Please use this page if there is more than one injured person from the accident.

Name:		Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Or Pedestrian: <input type="checkbox"/>	
Street Address:			
City:		State: <input type="checkbox"/>	Zip Code:
Injuries:			
Name:		Phone Number:	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Or Pedestrian: <input type="checkbox"/>	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Or Pedestrian: <input type="checkbox"/>	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Or Pedestrian: <input type="checkbox"/>	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Vehicle: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		Or Pedestrian: <input type="checkbox"/>	
Street Address:			
City:		State:	Zip Code:
Injuries:			
Name:		Phone Number:	
Street Address:			
City:		State:	Zip Code:
Injuries:			