

ACCIDENT REPORTING INSTRUCTIONS

Available 24/7 - Call 800-325-3619

All accidents must be reported to Vanliner Insurance Company. In the event of an accident, please follow these instructions:

1. Stop immediately and call 800-325-3619.
2. Call your Supervisor.
3. Protect the accident scene by placing appropriate warning devices and activating your hazard lights. Per DOT regulations, you must deploy your warning triangles within the first 10 minutes of the accident. See page 3 for reflective triangle placements. If possible, post a person to warn oncoming traffic.
4. Fuel Spill: Report immediately and follow applicable fuel spill procedures on page 4.
5. If possible, protect your equipment and cargo from further damage and/or theft. However, do NOT disturb the accident scene. Additionally, do not move your equipment until police arrive, if possible.
6. Be courteous, but do not sign anything or discuss the accident with anyone except the police, your supervisor and the Vanliner adjuster. Make sure you ask for verification of proper identification.
7. Do not admit responsibility or agree to pay for any damages or injuries of any kind.
8. Obtain witness statements using the Witness Information Forms found on page 6.
9. Complete the Accident Report Form on page 5 and email it to the Vanliner Claims department at claims@vanliner.com as soon as possible.
10. 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.
11. If required by DOT guidelines (see page 2) 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.

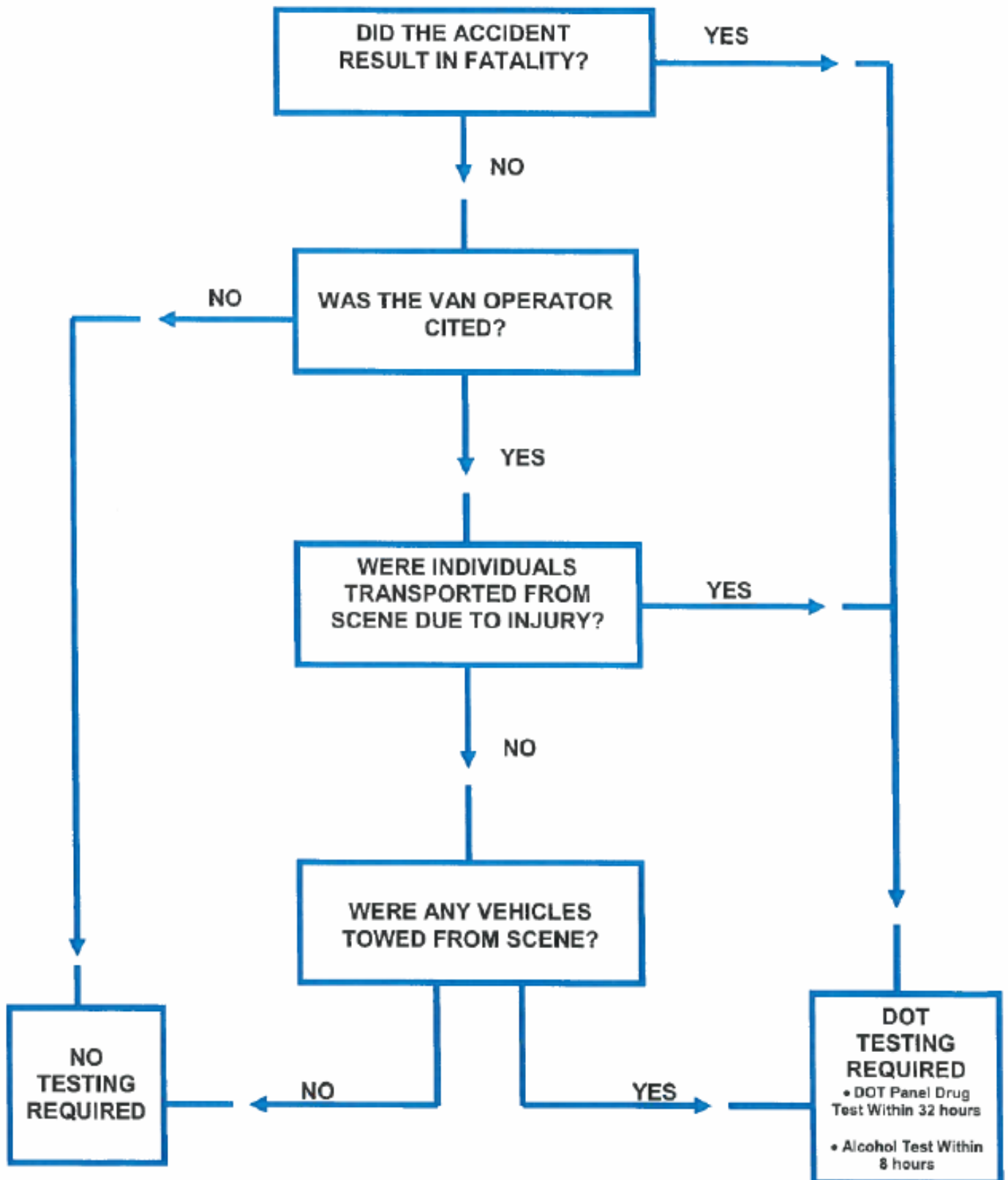
REPORT AN ACCIDENT - 24 HOURS A DAY
800-325-3619



A National Interstate Company.

One Premier Drive | Fenton, Missouri 63026 | 800-325-3619 | vanliner.com

FMCSR 382.303 POST-ACCIDENT DRUG & ALCOHOL TESTING



REFLECTIVE TRIANGLE PLACEMENT

Per Federal Motor Carrier Safety Regulations, you must deploy your warning triangles within the first 10 minutes of the accident.

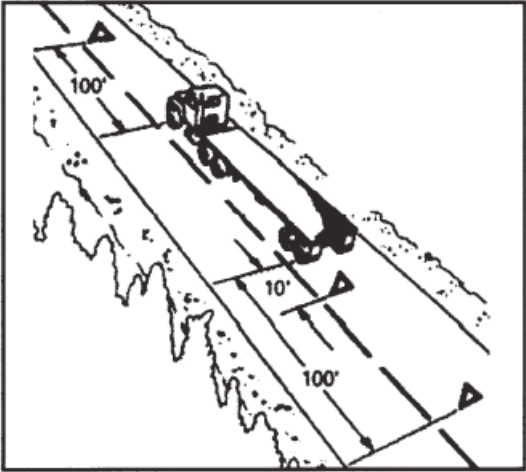


Figure 1

Stopped on an undivided highway: Place reflective triangles on the traffic side of the vehicle 10 and 100 feet behind the vehicle and 100 feet in front of vehicle to warn approaching traffic.

Stopped on a divided highway: Place reflective triangles on the traffic side of the vehicle 10 feet, 100 feet and 200 feet toward approaching traffic.

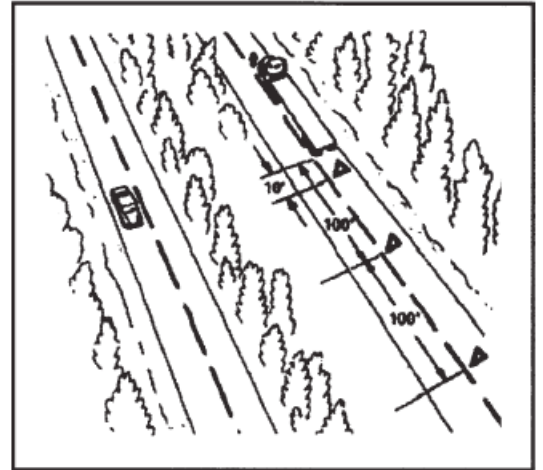


Figure 2

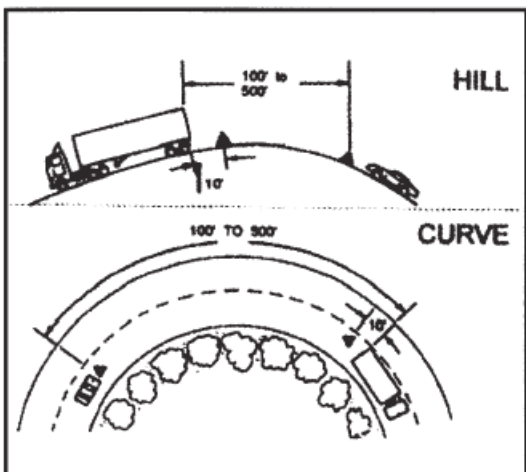


Figure 3

Stopped on a hill, curve or other obstructed location that prevents other drivers from seeing your vehicle within 500 feet: Place reflective triangles on the traffic side 10 feet behind vehicle and 100 to 500 feet further to warn approaching traffic. Distance depends on grade of hill or degree of curve.

FUEL SPILL PROCEDURES

1. Stop immediately.
2. Turn off engine.
3. Set out emergency triangles as required by the DOT. See page 3.
4. Deploy "Fuel Spill Kit" (if provided by employer).
5. If possible do not stop over sewer/drain.
6. Again, take pictures of the scene/spill area.
7. Report immediately to Vanliner! 800-325-3619.

REQUIRED INFORMATION

1. Location of spill: _____

2. Site contact – driver's cell number: _____
3. Type of spill (fuel or other material): _____

4. Area impacted: soil, grass, asphalt, concrete, and/or water: _____

5. Area fuel has or is flowing into; i.e. sewer, drainage ditch, surface water, etc: _____

6. How much fuel has been lost: _____



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 & Time of Loss:	Driver Name:	
Location of Accident (street/city/state):		
Year/Make/VIN of Insured Vehicle:		
Passenger Name(s):		
Passenger Phone Number(s):		

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: claims@vanliner.com <input type="checkbox"/>	Call: 800-325-3619 <input type="checkbox"/>

WITNESS INFORMATION FORM

Complete and Email to: claims@vanliner.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, which vehicle: _____ Were you injured? Yes No

If yes, please describe your injuries: _____

Did you know any of the parties involved in the accident? Yes No

If yes, list names and how you know him/her:

Describe the accident and what you saw:

Our Driver Name: _____ Our Company: _____

YOUR CONTACT INFORMATION

Your Name: _____

Phone Number: _____

Street Address: _____

City, State, Zip: _____



WITNESS INFORMATION FORM

Complete and Email to: claims@vanliner.com.

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Did you know any of the parties involved in the accident? Yes No

If yes, list names and how you know him/her:

Describe the accident and what you saw:

Our Driver Name: _____ Our Company: _____

YOUR CONTACT INFORMATION

Your Name: _____

Phone Number: _____

Street Address: _____

City, State, Zip: _____



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: