Driver Questionnaire

More Than Just Insurance.
Plymouth Rock assurance

To complete this form by hand:

1. Print all pages of the form.
2. Complete the form by filling in each space with black or blue ink. Do not use pencil.
3. When finished, mail the form to Plymouth Rock's Claims Department at the address provided at the bottom of the form.

Or

To complete this form electronically:

1. Save this writable PDF to your computer, then open it using Adobe's Acrobat Reader.
2. Complete the form by typing in each field and/or checking the appropriate buttons. *Tip: you can tab from field to field.*
3. When finished, save and print the form. Then mail the form to Plymouth Rock's Claims Department at the address provided at the end of the form.

Complete this form to the best of your knowledge and belief. DO NOT GUESS at any answers. If you don't know the answer to a question, leave that field blank. Please call your Claim Representative if you need help.

CLAIM NUMBER	*(12-digit number)*

DRIVER'S PERSONAL INFORMATION

Driver's **First** Name:		Driver's **Last** Name:	
Driver's License Number:	Date of Birth: / /		
Street Address:	City:	State:	Zip Code:
Home Phone: ( ) -	Work Phone: ( ) -	Cell Phone: ( ) -	

INFORMATION ABOUT THE VEHICLE YOU WERE DRIVING (VEHICLE 1)

Year:	Make:	Model:	License Plate Number:
Are you the owner of this vehicle? ◯ Yes ◯ No		IF NO, please provide owner's name and your purpose for using the vehicle.	
Owner's **First** Name:		Owner's **Last** Name:	
Purpose of Your Use of Vehicle:			
Number of Passengers:	IF ANY, please list the **first** and **last name** of each passenger below.		
Passenger 1:		Passenger 2:	
Passenger 3:		Passenger 4:	

ADDITIONAL VEHICLES INVOLVED IN THE ACCIDENT *(If needed, provide additional information on a separate page.)*

Additional Vehicle 2	Year:	Make:	Model:	License Plate Number:
	Driver's First & Last Name:			Driver's License Number:
	Insurance Company:			Policy Number:
	Number of Passengers:	IF ANY, please list the **first** and **last name** of each passenger below.		
	Passenger 1:		Passenger 2:	
	Passenger 3:		Passenger 4:	
Additional Vehicle 3	Year:	Make:	Model:	License Plate Number:
	Driver's First & Last Name:			Driver's License Number:
	Insurance Company:			Policy Number:

Form continues

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Additional Vehicle 3	Number of Passengers:	IF ANY, please list the **first** and **last name** of each passenger below.	
	Passenger 1:		Passenger 2:
	Passenger 3:		Passenger 4:

DETAILS ABOUT THE ACCIDENT

Date of Accident: / /	Time of Accident: : ◯ am ◯ pm	
Location of Accident:		

Your Vehicle (1)	Travel Direction: *(North, South, East, or West)*	Speed: *(mph)*	
Additional Vehicle 2	Travel Direction: *(North, South, East, or West)*	Speed: *(mph)*	
Additional Vehicle 3	Travel Direction: *(North, South, East, or West)*	Speed: *(mph)*	

Describe the Accident's Sequence of Events *(If needed, provide additional information on a separate page.)*

What happened first?

What happened second?

What happened third?

What happened fourth?

As a result of the accident,

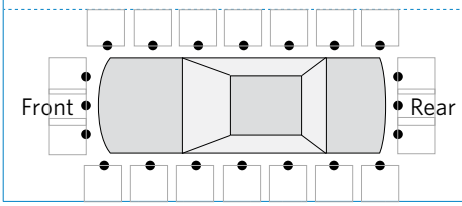
were you injured? ◯ Yes ◯ No	IF YES, what were your injuries?	
was anyone else injured? ◯ Yes ◯ No	IF YES, please provide names and associated injuries in the spaces below.	

Person 1	First & Last Name:	Injuries:
Person 2	First & Last Name:	Injuries:
Person 3	First & Last Name:	Injuries:

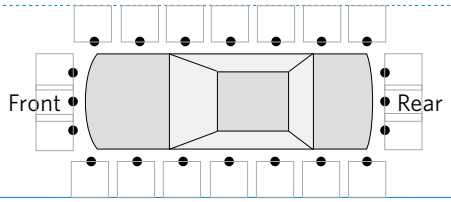
(If needed, please provide additional names and injuries on a separate page.)

Initial Impact *(Please mark all points of impact on each vehicle using an 'X'.)*

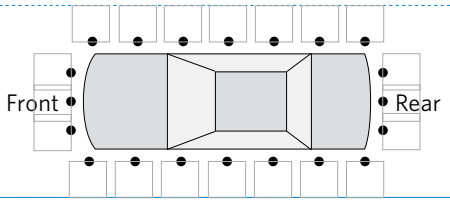
Vehicle 1 ***(Your Vehicle)***



Vehicle 2



Vehicle 3



Describe the Damage to Each Vehicle *(If needed, provide additional information on a separate page.)*

Vehicle 1	Damage:
Vehicle 2	Damage:
Vehicle 3	Damage:

Form continues

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Weather Conditions at the Time of the Accident *(e.g., Raining, Snowing, Foggy, Clear, etc.)*

Did anyone have a traffic control (i.e., stop sign, traffic light, etc.)? ◯ Yes ◯ No	
Did police come to the accident scene? ◯ Yes ◯ No	IF YES, which police department?
Were any citations issued? ◯ Yes ◯ No	IF YES, to whom? *(First & Last Name)*

Is there any more information about this accident you would like to provide?

Witnesses to the Accident *(If needed, please provide additional names and injuries on a separate page.)*

Were there any witnesses that were not passengers in any vehicles involved? ◯ Yes ◯ No — IF ANY, please provide information below.

Witness 1	First & Last Name:		Best Contact Phone: ( ) -	
	Street Address:	City:	State:	Zip Code:
Witness 2	First & Last Name:		Best Contact Phone: ( ) -	
	Street Address:	City:	State:	Zip Code:
Witness 3	First & Last Name:		Best Contact Phone: ( ) -	
	Street Address:	City:	State:	Zip Code:
Witness 4	First & Last Name:		Best Contact Phone: ( ) -	
	Street Address:	City:	State:	Zip Code:

Form continues

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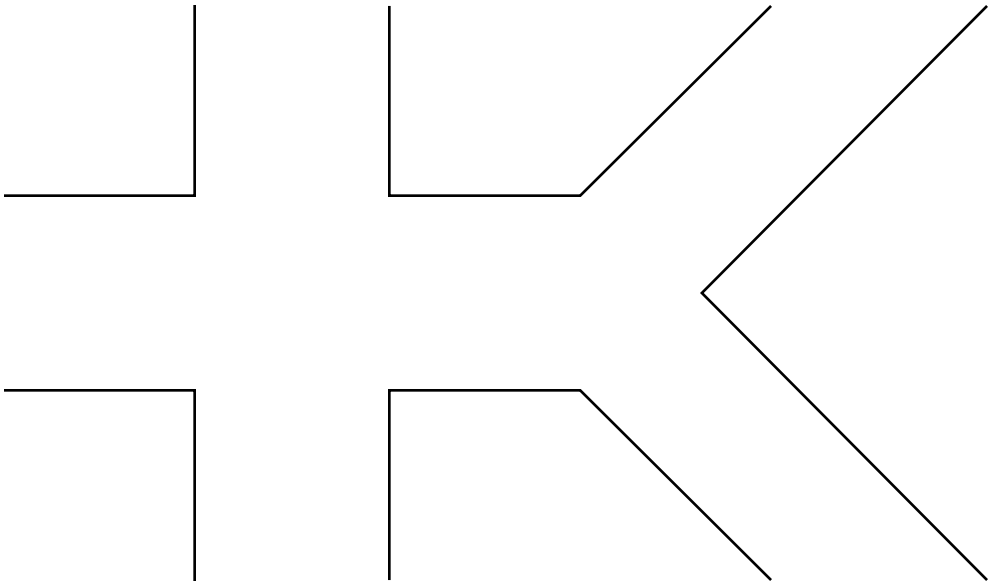
Please use the following diagram to give a visual representation of how the accident occurred.



Indicate the vehicles involved and direction of travel using the following symbols:

= Direction

1 = Your Vehicle

2 = Vehicle 2

3 = Vehicle 3

= Pedestrian

✘ _____ / / _____

Driver's Signature | Date

Return This Form To

Claims Department
Plymouth Rock Assurance Corporation, PO Box 9112, Boston, MA 02112-9112

Thank you.