

South Australia Compulsory Third Party (CTP)

Accident Report Form

This form is to be completed by the driver, motor cyclist or registered owner, when a person is injured or a fatality occurs in a motor vehicle accident.

A separate form (Injury Claim Form) should be completed by any person injured in the accident.

A Fatality Claim Form should be completed by a person who is claiming compensation as a result of a person's death in a motor vehicle accident.

This form must be lodged with the approved CTP insurer of your vehicle.

If you have any queries, please call the CTP Insurance Regulator on 1300 303 558 (cost of a local call).

Alternatively further information may be found on the CTP Insurance Regulator website. This is located at www.ctp.sa.gov.au

PLEASE COMPLETE THIS FORM IN EITHER BLUE OR BLACK PEN.

Other languages

If you need an interpreter please telephone the Interpreting and Translating Centre on 1800 280 203 and ask to be connected to the CTP Insurance Regulator on 1300 303 558, between 8.30am and 5.00pm, Monday to Friday.

Chinese/中文

如果你需要翻译，请于星期一至星期五，上午8：30至下午5：00拨打翻译和口译中心（Interpreting and Translating Centre）的电话：1800 280 203，请他们帮你接通CTP保险监督的电话：1300 303 558。

Greek/Ελληνικά

Αν χρειάζεστε διερμηνέα σας παρακαλούμε τηλεφωνήστε στο Κέντρο Διερμηνείας και Μετάφρασης (Interpreting and Translating Centre) στο 1800 280 203 και ζητήστε να σας ενώσουν με το Ρυθμιστή Ασφάλισης Τρίτου Μέρους (CTP Insurance Regulator) στο 1300 303 558, μεταξύ 8.30 πμ και 5.00 μμ, Δευτέρα μέχρι Παρασκευή.

Hindi/हिन्दी:

यदि आपको दुभाषिया की आवश्यकता है तो कृपया Interpreting and Translating Centre को 1800 280 203 पर फोन करें और उनसे कहें कि आपको CTP Insurance Regulator से 1300 303 558 पर मिला दें। CTP Insurance Regulator का कार्यालय सोमवार से शुक्रवार को सुबह 8.30 से 5.00 के बीच खुलता है।

Italian/Italiano

Se hai bisogno di un interprete, telefona al Centro Interpreti e Traduttori (Interpreting and Translating Centre) al numero 1800 280 203 e chiedi di collegarti al Regolatore Assicurativo CTP (CTP Insurance Regulator) al numero 1300 303 558, fra le 8.30 e le 17.00, dal lunedì al venerdì.

Vietnamese/Tiếng Việt

Nếu quý vị cần một thông dịch, vui lòng gọi điện thoại cho Trung Tâm Thông Phiên Dịch (Interpreting and Translating Centre) theo số điện thoại 1800 280 203 và yêu cầu được nối máy đến Cơ Quan Kiểm Soát Bảo Hiểm Bên Thứ Ba Bắt Buộc (CTP Insurance Regulator) theo số 1300 303 558, trong khoảng thời gian từ 8.30 sáng đến 5.00 chiều, từ thứ Hai đến thứ Sáu.

About the accident

Office Use: Accident Number

- 1 Date of accident / / Day of accident
-
- 2 Time of accident _____ am/pm
-
- 3 Place of accident
 Suburb _____ Postcode _____
-
- 4 Nearest cross road _____
-
- 5 Description of the accident. *(Describe how the accident happened and include a reference to road conditions, speed, traffic lights, road signs, peak hour etc and details of vehicle damage).*

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Please continue on Page 11 if you need to include more information.

- 6 Please mark with ✘ damaged areas of the vehicle. Please mark with ✓ where occupants of cars were seated in all vehicles (if known).



7 Registration number: _____ (your vehicle)

Registration number: _____ (vehicle 2)

Registration number: _____ (vehicle 3)

- 8 Diagram of accident. *(Please draw a diagram of the accident. Include intersections, streets, roads and their names. Show the point of impact and position of all vehicles).*

Symbols to use

traffic sign traffic lights

witness pedestrian

your vehicle (black) other vehicles 1, 2, 3

Example diagram for vehicle

Example diagram for pedestrian/cyclist

Check list

Please show street names lanes/lines markings traffic signals/signs

- 9 Road conditions *(mark the conditions which apply to your accident)*
- Road conditions: Wet Dry Sealed Unsealed
-
- Traffic conditions: Heavy Medium Light
-
- Traffic controls: None Stop sign Give Way sign
- Traffic Light Roundabout
-
- Weather conditions: Fine Raining Foggy
-
- Lighting Conditions: Day Dusk Night Dawn
-
- 10 Was the accident your fault?: Partly Yes No

About my accident

- 11 Estimated speed of vehicles
Prior to collision: Your vehicle kph / Other vehicle kph
When collision occurred: Your vehicle kph / Other vehicle kph
- 12 Were vehicle lights on?
Your vehicle: No Low beam High beam
Other vehicle: No Low beam High beam
- 13 Were indicators operating?
Your vehicle: Yes No
Other vehicle: Yes No
- 14 Was your vehicle driveable after the accident?
Your vehicle: Yes No
Other vehicle: Yes No
- 15 Was your vehicle towed away?
Your vehicle: Yes No
Other vehicle: Yes No
- 16 Name of the repairer of your vehicle *(Please attach a quote if you have one)*
- 17 Name of the property damage insurer of your vehicle
- 18 Was the accident: Very minor Minor Moderate Severe
- 19 Approximate cost of your repairs *(if quote is not attached)*

Insured owner details

- 20 Title: Mr Ms Mrs Miss Other
- 21 Surname:
- 22 Given names:
- 23 Date of birth: / /
- 24 Address:
Postcode:
- 25 Was the insured owner entitled to any input tax credits for the GST included in the CTP premium? Yes No
- 26 Was the vehicle being used for business at the time of the accident? Yes No

Driver details

- 27 Title: Mr Ms Mrs Miss Other
- 28 Surname:
- 29 Given names:
- 30 Date of birth: / /
- 31 Country of birth:
- 32 Language spoken at home:
- 33 Do you require an interpreter? Yes No
- 34 Home address:
Postcode:

- 35 Postal address:
Postcode:
- 36 Home phone no: ()
Work phone no: ()
Mobile no:
- 37 Email:
- 38 Occupation:
- 39 Place of employment:
- 40 Driver's licence no: *(please attach a photocopy of your current licence)*
State Expiry date / /
- 41 Was the vehicle driven with the owner's consent?
 Not applicable Yes No
If no, please state reason:
- 42 Were you holding a mobile phone at the time of the accident? Yes No
- 43 Were you wearing a seatbelt/helmet? Yes No
If no, please state reason:
- 44 Did you consume any alcohol, drugs or medication in the 12 hours prior to the accident? Yes No
If yes, please give details of how much, what and when:
- 45 (i) Was a breathalyser test taken at the scene? Yes No
If Yes, provide result(s) and attach docket if provided
(ii) Was a drug test taken? Yes No
If yes, what was the result?
(iii) Did you go to hospital? Yes No
(iv) Did you have a blood test taken? Yes No
If yes, please provide result and attach certificate
If not available please provide at first available opportunity
- 46 Nominate the at fault vehicle (registration) you consider caused the accident:

My vehicle details

47 Registration no: _____ State of registration: _____
48 Year: (e.g. 1990) _____
49 Make: (e.g. Holden) _____
Model: (e.g. Commodore VN) _____
Body type (e.g. Sedan) _____
50 Colour: _____

Police details

51 Did the Police come to the scene of the accident?
_____ Unknown Yes No

52 Did you report the accident to the Police? Yes No
If yes, Police report no: _____
Police station: _____

**All accidents resulting in injuries should be reported to the Police.*

53 Is Police action going to be taken? Unknown Yes No
If yes, name of person charged: _____
Offence committed: _____

54 Were there any unusual circumstances in the accident
(e.g. alcohol, drugs, false details)? Unknown Yes No
If yes, please provide details _____

Second vehicle details

55 Registration no: _____ State of registration: _____
56 Year: (e.g. 1990) _____
57 Make: (e.g. Holden) _____
Model: (e.g. Commodore VN) _____
Body type (e.g. Sedan) _____
58 Colour: _____
59 Title: Mr Ms Mrs Miss Other _____
60 Driver surname: _____
61 Given names: _____
62 Phone no: () _____
Address: _____
Postcode: _____

Third vehicle details (if applicable)

63 Registration no: _____ State of registration: _____
64 Year (e.g. 1990) _____
65 Make: (e.g. Holden) _____
Model: (e.g. Commodore VN) _____
Body type (e.g. Sedan) _____
65 Colour _____

66 Title: Mr Ms Mrs Miss Other _____
67 Driver Surname: _____
68 Given names: _____
69 Phone no: () _____
Address: _____
Postcode: _____

Independent witness(es) details

70 Were there any independent witnesses? Yes No
If yes, please give details: _____

If no, please go to Question 73.

71 Witness 1

Surname: _____
Given names: _____
Home address: _____
Postcode: _____
Home phone no: () _____
Work phone no: () _____
Mobile no: _____

72 Witness 2

Surname: _____
Given names: _____
Home address: _____
Postcode: _____
Home phone no: () _____
Work phone no: () _____
Mobile no: _____

Passenger details

73 If you were carrying passengers in your vehicle please give details

.....
.....
.....

If no, please go to Question 76

74 Passenger 1

Title: Mr Ms Mrs Miss Other

Surname:

Given names:

Home address:

Postcode:

Home phone no: ()

Work phone no: ()

Mobile no:

Date of birth: / /

Occupation:

Was the passenger injured? Yes No

If yes, nature of injury:

.....
Did this passenger go to hospital? Yes No

Was this injured passenger wearing a seatbelt/helmet at the time of accident? Unknown Not applicable Yes No

75 Passenger 2

Title: Mr Ms Mrs Miss Other

Surname:

Given names:

Home address:

Postcode:

Home phone no: ()

Work phone no: ()

Mobile no:

Date of birth: / /

Occupation:

Was the passenger injured? Yes No

If yes, nature of injury:

.....
Did this passenger go to hospital? Yes No

Was this injured passenger wearing a seatbelt/helmet at the time of accident? Unknown Not applicable Yes No

Please continue on the back page if you need to include more information

76 Were there any passengers in the other vehicles?

Unknown Yes No

If yes, please give details:

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.....
.....

77 Was any person in the other vehicle(s) known to you? Yes No

If yes, please state name and relationship (e.g. friend, relative, etc)

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.....

78 Was anyone else including yourself, in the accident injured? Yes No

Was there a fatality arising from the accident? Yes No

If yes, please give details below of all persons sustaining injuries in this accident

.....

If no, please go to the Declaration.

Title: Mr Ms Mrs Miss Other

Surname:

Given names:

Home phone no: ()

Work phone no: ()

Mobile no:

Date of birth: / /

Home address:

Postcode:

Occupation:

Nature of injury:

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.....

Was the person wearing a seatbelt/helmet? Yes No

Was the person a: Driver Passenger Motorcyclist
 Pillion Pedestrian

What vehicle was the person travelling in?

Insured vehicle Other vehicle Not applicable

Name of person completing the form: (if not the driver of the vehicle)

.....
Address:

Postcode:

Reason why driver of vehicle is not completing this form?

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Acknowledgement

Questions in this form requesting information as to fault are not required by statute, and do not require you to assess who is at fault as a matter of law. You are requested to provide this information simply to assist with initial administration of the claims process.

Any information provided on this form as to fault is indicative only and can not constitute an admission of fault or wrongdoing by any person for legal purposes.

Under the *Motor Vehicles Act 1959* (SA) (MV Act) an accident caused by, or arising out of the use of, a motor vehicle that results in the death of, or bodily injury to, any person, must be notified in writing to the insurer who provides CTP insurance for that vehicle.

This form contains the information required under the MV Act and additional information requested for administrative purposes. If you do not provide all of the information set out in this form, and you are the driver, owner or person who was in control of the vehicle at the time of the accident, you may be guilty of an offence under the MV Act, punishable by a penalty of up to \$1,250 or imprisonment for up to 3 months.

Personal information (including sensitive information) collected in this form and throughout the course of any subsequent CTP insurance claim will be collected and handled for the purpose of managing, assessing and investigating any such claim, to handle associated complaints and disputes, associated business activities and detecting fraud.

By lodging this form you consent to your personal information being collected and handled for the purposes above, in accordance with the MV Act, the *Compulsory Third Party Insurance Regulation Act 2016* (SA), this privacy statement and as otherwise authorised or required by law. Your consent also covers the collection of personal information (including sensitive information) from you and as otherwise required or authorised by law.

Your personal information may be disclosed between your approved CTP insurer, the CTPI Regulator, the Nominal Defendant, other approved CTP insurers, and other government agencies and third parties involved in the assessment of any claim related to the accident described in this form (including those described in the Authority on this form), and as otherwise authorised or required by law.

Each of these parties will collect and handle this information (including all personal information and sensitive information) for the same purposes set out above.

The privacy policy of each approved CTP insurer contains information about how you may access the personal information the insurer holds about you, how you may complain about a breach of the Australian Privacy Principles by the insurer and how they will handle a complaint. The name and contact details for privacy enquiries for each insurer who provides CTP insurance in South Australia, is set out on the South Australian CTP Regulator's website below, along with a link to their privacy policy.

www.ctp.sa.gov.au/insurers

Declaration

The above is a true statement of the facts and matters relating to the accident in respect of which this report is made.

I (full name)

solemnly and sincerely declare that, to the best of my knowledge, the information given in this Accident Report Form is true and correct in every respect.

Under Section 124(6a) of the *Motor Vehicles Act 1959*, you can be fined up to \$50,000 or be imprisoned for up to one year for knowingly providing false or misleading information.

Signature of driver:

.....
Date: / /

Details and signature of witnessing party

(any person over 18 years of age)

Full name of witness:

Signature of witness:

.....
Date: / /

Authority

I hereby authorise the approved CTP insurer who handles a claim in connection with the accident described on this form (whether or not it is the approved insurer this form is originally lodged with) **(approved insurer)** to settle or defend any claim or proceedings that may arise and to make any admission which in its decision is necessary.

This authority shall be deemed a warrant of authority for the approved insurer's solicitors to act for me in connection with any claim or proceedings.

I authorise the approved insurer and any agents, acting on behalf of the approved insurer or the Nominal Defendant;

- To obtain copies of any statements made by me to the Police Department of any State or Territory.
- To either take possession of my vehicle and/or recover from my vehicle any part(s) for examination in connection with any potential injury claim arising from this accident
- To contact and obtain information and documents relevant to the claim, from, and to provide information set out on this form to
 - Police Departments of any State or Territory
 - Hospitals, including private hospitals
 - Health practitioners
 - Ambulance and other emergency services
 - Professional providers of rehabilitation services or persons professionally qualified to assess; cognitive, functional or vocational capacity
 - Educational institutions
 - My employer or my previous employer
 - Departments, agencies or instrumentalities of the Commonwealth, the State or another State, administering laws about health, policy, transport, taxation or social welfare
 - the Lifetime Support Authority of South Australia
 - ReturnToWorkSA
 - Insurers that carry on the business of providing compulsory third party insurance, private health insurance, motor vehicle insurance and/or workers compensation insurance
 - State Forensic Centre
 - Any property insurer
 - All of the above pursuant to the *Freedom of Information Act 1991 (SA)* where applicable

Signature of driver:

.....
Date: / /

Details and signature of witnessing party

(any person over 18 years of age)

Full name of witness:

Signature of witness:

.....
Date: / /

Signature of insured owner:

.....
Date: / /

Return to your approved CTP insurer.

Additional space

Space used for further information

Dotted lines for writing space.

Please attach extra pages if required

Additional space

Space used for further information

A large area of horizontal dotted lines for writing, divided into two columns by a vertical line. A central diamond-shaped callout box is positioned over the vertical line.

Please
attach extra
pages if
required

Additional space

Space used for further information

Lined writing area consisting of two columns of horizontal dotted lines separated by a vertical green line.

Please
attach extra
pages if
required



We appreciate that your time is valuable; however the more information you can supply at this stage will assist us in processing your documentation.

Have you completed the following questions?

- Q1 Date of accident (including approximate time).
.....
- Q3 Place of accident – road and suburb.
.....
- Q5 Description of accident circumstances.
.....
- Q46 Nominated the at fault motor vehicle (registration) you consider caused the accident.
.....
- Q55 & Q63 Registration number of any other vehicles involved in the accident.
.....
- Completed the Declaration and Authority section after Q78 and has this been witnessed by a person 18 years of age or older?
.....
- Attached a copy of your drivers licence, breath analysis and /or drug analysis docket, or Blood Alcohol certificate where available.
.....

Please ensure that all other sections of the form/s are completed to the best of your ability.

If you have any questions about the completion of the forms please contact the CTP Insurance Regulator on 1300 303 558 and we will be happy to assist with your enquiry.