

DEPARTMENT OF MOTOR VEHICLES
 Agency of Transportation
 120 State Street
 Montpelier, Vermont 05603-0001
 (voice) 802.828.2050
 dmv.vermont.gov

A crash with more than 2 vehicles involved must fill out as many forms as needed to include all vehicles involved in the crash.

FOR OFFICE USE ONLY

DMV Crash Number

ALL INFORMATION REQUESTED MUST BE COMPLETED IN FULL IN INK OR TYPEWRITTEN

THE OPERATOR OF EVERY MOTOR VEHICLE INVOLVED IN A CRASH WHICH RESULTS IN INJURY OR DEATH OR TOTAL PROPERTY DAMAGE OF \$3,000.00 OR MORE, MUST MAKE A REPORT ON THIS FORM WITHIN 72 HOURS TO THE ABOVE ADDRESS. YOU MUST REPORT EVEN IF VEHICLE WAS PARKED. THE FAILURE OR REFUSAL OF ANY PERSON TO REPORT MAY BE PUNISHABLE BY A CIVIL PENALTY.

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|--|--------------------|--------------------------------|--------------------------------------|--------------------------------------|
| TIME OF CRASH <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | DAY OF WEEK | MONTH/DAY/YEAR OF CRASH | PLACE OF CRASH (CITY OR TOWN) | STREET/ROUTE/HIGHWAY OF CRASH |
|--|--------------------|--------------------------------|--------------------------------------|--------------------------------------|

IF YOUR (OPERATOR #1) ADDRESS IS DIFFERENT FROM THE ADDRESS ON DMV RECORDS AND THIS FORM IS SIGNED BY YOU THIS FORM WILL BE CONSIDERED TO BE A NOTICE OF ADDRESS CHANGE AND YOUR ADDRESS WILL BE CHANGED ON DMV RECORDS.

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|---|--|---|---|---|---|---|------------------------------------|
| YOUR VEHICLE ~ NO. 1 | | | | OTHER VEHICLE ~ NO. 2 OR PEDESTRIAN OR BICYCLIST | | | |
| NUMBER OF OCCUPANTS | | | | NUMBER OF OCCUPANTS | | | |
| OPERATOR NAME: LAST FIRST MIDDLE | | | | OPERATOR NAME: LAST FIRST MIDDLE | | | |
| STREET OR BOX NO. | | | | STREET OR BOX NO. | | | |
| CITY OR TOWN | | | STATE | CITY OR TOWN | | | STATE |
| ZIP CODE | | DATE OF BIRTH | | ZIP CODE | | DATE OF BIRTH | |
| OPERATOR'S LICENSE NO. | | CLASS | STATE | | OPERATOR'S LICENSE NO. | | CLASS |
| IDENTIFICATION NUMBER | | PLATE NUMBER | PLATE STATE | | IDENTIFICATION NUMBER | | PLATE NUMBER |
| VEHICLE YEAR | VEHICLE MAKE | VEHICLE MODEL | VEHICLE TYPE | | VEHICLE YEAR | VEHICLE MAKE | VEHICLE MODEL |
| TRAILER YEAR | TRAILER MAKE | TRAILER MODEL | TRAILER PLATE # | | TRAILER YEAR | TRAILER MAKE | TRAILER MODEL |
| COMMERCIAL VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO | | HAZARDOUS MATERIAL <input type="checkbox"/> YES <input type="checkbox"/> NO | | COMMERCIAL VEHICLE <input type="checkbox"/> YES <input type="checkbox"/> NO | | HAZARDOUS MATERIAL <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| ACTUAL COST OF VEHICLE #1 REPAIRS | IF THE CRASH INVOLVED A PEDESTRIAN OR A BICYCLIST, COMPLETE THE FOLLOWING INFORMATION | | | | | | ACTUAL COST OF VEHICLE #2 REPAIRS |
| PROPERTY DAMAGE OTHER THAN VEHICLE | WHAT WAS PEDESTRIAN OR BICYCLIST DOING | | | | | | PROPERTY DAMAGE OTHER THAN VEHICLE |
| APPROXIMATE COST OF PROPERTY REPAIRS | <input type="checkbox"/> WALKING WITH TRAFFIC | <input type="checkbox"/> WALKING AGAINST TRAFFIC | <input type="checkbox"/> NOT IN ROADWAY | <input type="checkbox"/> PLAYING IN ROAD | <input type="checkbox"/> GETTING ON/OFF VEHICLE | <input type="checkbox"/> PUSHING VEHICLE | <input type="checkbox"/> UNKNOWN |
| PROPERTY OWNER'S NAME AND ADDRESS: | <input type="checkbox"/> CROSSING INTERSECTION | <input type="checkbox"/> CROSSING NOT AT AN INTERSECTION | OTHER: | <input type="checkbox"/> WORKING ON VEHICLE | <input type="checkbox"/> RIDING/PUSHING BIKE | PROPERTY OWNER'S NAME AND ADDRESS: | |
| PROPERTY OWNER'S NAME AND ADDRESS: | DESCRIBE INJURY: | | | | | | PROPERTY OWNER'S NAME AND ADDRESS: |

OCCUPANT DATA

THE INFORMATION BELOW IS REQUIRED FOR YOURSELF AND ALL OCCUPANTS IN ALL VEHICLES (ATTACH ADDITIONAL SHEETS IF THERE IS NOT ENOUGH ROOM BELOW)

| OCCUPANT'S NAME AND ADDRESS (USE THE FIRST LINE FOR YOURSELF EVEN IF NOT INJURED) | NATURE AND EXTENT OF INJURY (STATE "NONE" IF NOT INJURED) | NAME OF HOSPITAL INJURED TAKEN TO | THIS INFORMATION IS REQUIRED | | | | | |
|---|---|-----------------------------------|------------------------------|-------------------------|-------------|--------|------------------------------|----------------------------------|
| | | | VEH NO | POSITION WITHIN VEHICLE | AGE OF OCC. | GENDER | WAS SEATBELT OR HARNESS USED | WAS OCCUPANT THROWN FROM VEHICLE |
| | | | 1 | YOURSELF DRIVER | | | | |
| | | | | | | | | |
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CONTINUE ON NEXT PAGE

DESCRIBE IN YOUR OWN WORDS WHAT HAPPENED (ATTACH SHEET IF NECESSARY)

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| WAS THIS CRASH INVESTIGATED BY AN OFFICER? <input type="checkbox"/> Yes <input type="checkbox"/> No | IF YES, GIVE NAME OF OFFICER: |
| OFFICER'S DEPARTMENT: | |

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| WERE YOU DRIVING A COMMERCIAL VEHICLE? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| WAS THE VEHICLE TRANSPORTING HAZARDOUS MATERIALS? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| IF YES, GIVE NAME OF MATERIAL |


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| OPERATOR SIGN HERE  | DATE OF REPORT |
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IMPORTANT: YOU MUST FURNISH THE INSURANCE INFORMATION REQUESTED.

Vermont law requires that any person involved in a crash which has resulted in bodily injury or death to any person or whereby the motor vehicle then under his control or any other property is damaged in an aggregate amount to the extent of \$3,000 or more must furnish the commissioner with satisfactory proof that a standard provisions automobile liability insurance policy was in full force and effect at the time of the crash.

Any person who fails to furnish satisfactory proof that liability insurance was in force at the time of the crash may be required to obtain and furnish proof that Financial Responsibility Insurance has been obtained covering such person in the future operation of any motor vehicle.

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| (OPERATOR #1) MUST COMPLETE BOTH SECTIONS BELOW IN FULL. IF YOU FAIL TO GIVE FULL INFORMATION BELOW, IT WILL BE ASSUMED THAT YOU DO NOT HAVE AUTOMOBILE LIABILITY INSURANCE AND A SUSPENSION OF YOUR LICENSE/PRIVILEGE TO OPERATE IN VERMONT WILL BE ISSUED. | DMV CRASH NUMBER |
| Was an Automobile Liability Insurance policy, providing you AT LEAST \$25,000/\$50,000 bodily injury and \$10,000 property damage insurance in effect on the date of the above crash? You must answer Yes or No. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name of your (Operator 1) Insurance Company (NOT AGENT): _____ | |
| Insurance Company Mailing Address: _____ | |
| Policy Number: _____ | Policy Period From: _____ to _____ |
| Name of Policy Holder: _____ | Address: _____ |
| Name of Operator at the time of the Crash: _____ | Date of Crash: _____ |
| Is this motor vehicle covered by a Certificate of Self-Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, certificate number: _____ | |

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|--|---|------------------------|
| DO NOT DETACH FORM SR-21A VERMONT | VERMONT DEPARTMENT OF MOTOR VEHICLES MONTPELIER VERMONT | DMV CRASH NUMBER |
| Name of insurance company with whom you are insured for liability or damage to others (For Operator #1): _____ | | |
| Insurance Company mailing address: _____ | | |
| Policy Number: _____ | Policy Period From: _____ | to _____ |
| Date of Crash: _____ | At or near (Town/City): _____ | |
| Make of your vehicle: _____ | Year: _____ | Type: _____ VIN: _____ |
| Operator: _____ | Address: _____ | |
| Name of Policy Holder: _____ | Signature of Operator: _____ | |
|  IMPORTANT!! THIS CRASH SHOULD ALSO BE REPORTED DIRECTLY TO YOUR INSURANCE COMPANY. FAILURE TO REPORT MAY JEOPARDIZE YOUR AUTOMOBILE LIABILITY | | |

DO NOT WRITE IN THE SECTION BELOW – IT IS FOR USE OF INSURANCE COMPANY ONLY

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| TO INSURANCE COMPANY : |
| Return this form in 15 days if no policy, or insufficient policy was in effect as alleged by motorist. IF NOTIFICATION IS NOT RECEIVED WITHIN 15 DAYS, IT WILL BE ASSUMED THE REQUIRED INSURANCE WAS IN EFFECT AT THE TIME OF THE CRASH. |
| TO COMMISSIONER OF MOTOR VEHICLES, MONTPELIER, VERMONT 05603-0001 |
| With regard to an insurance policy for the policy holder named on the reverse side hereof the undersigned insurance company advises you in accordance with the items checked below : |
| <input type="checkbox"/> 1. No such policy was in effect at the time of the crash. |
| <input type="checkbox"/> 2. Our policy applies to the owner of the vehicle but does not apply to the operator of the vehicle involved in the crash. |
| <input type="checkbox"/> 3. Our policy affords limits of liability less than \$25,000/\$50,000 bodily injury and \$10,000 property damage (indicate actual limits under remarks). |
| REMARKS : |
| NAME OF INSURANCE COMPANY : _____ BY : _____ |
| DATE : _____ AUTHORIZED REPRESENTATIVE |