

DEPARTMENT OF MOTOR VEHICLES <i>Agency of Transportation</i> 120 State Street Montpelier, Vermont 05603-0001 (voice) 802.828.2000 dmv.vermont.gov	<b>A crash with more than 2 vehicles involved must fill out as many forms as needed to include all vehicles involved in the crash.</b>	<b>FOR OFFICE USE ONLY</b> DMV Crash Number
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**ALL INFORMATION REQUESTED MUST BE COMPLETED 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 (THIS INCLUDES ALL VEHICLES INVOLVED AND PHYSICAL PROPERTY DAMAGE), 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. INSURANCE INFORMATION IS REQUIRED

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

<b>YOUR VEHICLE</b>	NUMBER OF OCCUPANTS	<b>OTHER VEHICLE OR PEDESTRIAN OR BICYCLIST</b>	NUMBER OF OCCUPANTS
<b>OPERATOR NAME:</b> LAST FIRST MIDDLE		<b>OPERATOR NAME:</b> LAST FIRST MIDDLE	
Street or Box No.		Street or Box No.	
City or Town		City or Town	
State		State	
Zip Code	Date of Birth	Gender	Zip Code
Operator's License No.	Class	State	Operator's License No. (If Known)
Class (If Known)	State		
Identification Number	Plate Number	Plate State	Identification Number
Plate Number	Plate State		
Vehicle Year	Vehicle Make	Vehicle Model	Vehicle Type
Trailer Year	Trailer Make	Trailer Model	Trailer Plate #
Commercial Vehicle <input type="checkbox"/> YES <input type="checkbox"/> NO		Hazardous Materials <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Commercial Vehicle <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Hazardous Materials <input type="checkbox"/> YES <input type="checkbox"/> NO	

ACTUAL COST OF VEHICLE #1 REPAIRS		<b>IF THE CRASH INVOLVED A PEDESTRIAN OR A BICYCLIST, COMPLETE THE FOLLOWING INFORMATION</b> WHAT WAS PEDESTRIAN OR BICYCLIST DOING	ACTUAL COST OF VEHICLE #2 REPAIRS	
PROPERTY DAMAGE OTHER THAN VEHICLE		<input type="checkbox"/> WALKING WITH TRAFFIC <input type="checkbox"/> PLAYING IN ROAD <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WALKING AGAINST TRAFFIC <input type="checkbox"/> GETTING ON/OFF VEHICLE <input type="checkbox"/> NOT IN ROADWAY <input type="checkbox"/> PUSHING VEHICLE	PROPERTY DAMAGE OTHER THAN VEHICLE	
APPROXIMATE COST OF PROPERTY REPAIRS		<input type="checkbox"/> CROSSING INTERSECTION <input type="checkbox"/> WORKING ON VEHICLE <input type="checkbox"/> CROSSING NOT AT AN INTERSECTION <input type="checkbox"/> RIDING/PUSHING BIKE	APPROXIMATE COST OF PROPERTY REPAIRS	
PROPERTY OWNER'S NAME AND ADDRESS:		OTHER: DESCRIBE INJURY:		

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	DRIVER				

<b>(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.</b>	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 <b>must</b> 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: _____	

DO NOT DETACH FORM SR-21A	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: _____		
<b>IMPORTANT!! THIS CRASH SHOULD ALSO BE REPORTED DIRECTLY TO YOUR INSURANCE COMPANY. FAILURE TO REPORT MAY JEOPARDIZE YOUR AUTOMOBILE LIABILITY</b>		

**PLEASE CONTINUE ON THE REVERSE SIDE OF THIS REPORT**

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

Lined area for describing the crash.

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

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

<b>OPERATOR SIGN HERE</b>	DATE OF REPORT
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**IMPORTANT: YOU MUST FURNISH THE INSURANCE INFORMATION REQUESTED FOR THE VEHICLE YOU WERE OPERATING.**

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.

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

**TO INSURANCE COMPANY**

Return this form within 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.** Send to :  
COMMISSIONER OF MOTOR VEHICLES, 120 STATE STREET, 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 :

1. No such policy was in effect at the time of the crash.

2. 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