

This form contains interactive fields - required fields are highlighted in light turquoise. Use the 'TAB' key to move to the next field; use 'SHIFT' + 'TAB' to move to the previous field; or use your mouse to click on the desired field.

The completed form must be submitted to us within seven (7) days of the incident. You can submit the form by mail to our Head Office at the address below; email it to us at [claims@bcferries.com](mailto:claims@bcferries.com); send by toll-free fax to 1-866-644-4547 or drop it off at one of our terminals.

BC Ferry Services Inc.  
Suite 500, 1321 Blanshard Street  
Victoria, BC V8W 0B7  
Attention: Risk Management Analyst

**Incomplete forms will result in a delay of the investigation/adjudication of your claim.**

### Claimant or Witness Information:

Please Print Name:	<input type="text"/>	Date:	<input type="text"/>		
Mailing Address:	<input type="text"/>				
City:	<input type="text"/>	Prov/State:	<input type="text"/>		
		Postal/Zip:	<input type="text"/>		
Country:	<input type="text"/>				
Home Phone:	<input type="text"/> <small>Area Code</small>	<input type="text"/> <small>Number</small>	Daytime Phone:	<input type="text"/> <small>Area Code</small>	<input type="text"/> <small>Number</small>
E-mail:	<input type="text"/>				

### Details of Incident:

<input type="text"/> Date of Incident	<input type="text"/> Approximate Time of Incident (use 24-hr clock)	<input type="text"/> Print EXACT Location of Incident
	On vessel <input type="text"/>	Terminal <input type="text"/>

*Continued on the next page*

**Details of Incident (cont'd):**

**Give a detailed description of what happened:**

**Type of Damage or Injury:** Property Damage  Bodily Injury

Other:  What Kind:

**Give a detailed description of the damage:**

*Continued on the next page*

### Details of Incident (cont'd):

<b>If bodily injury, was medical assistance given?</b>	Yes	No	
<b>If yes, what level?</b>	First Aid	Doctor	Hospital
<b>Were there witnesses?</b>	Yes	No	
<b>If yes, who?</b>	BCF Employee	Family Member/Friend	Other
			Who?
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Name of Witness #1	Name of Witness #2	Name of Witness #3	

**Was the incident reported to BC Ferries personnel at the time it happened?** Yes  No

If yes, who at BC Ferries did you give it to?

Name or Title

Location Where You Reported the Incident

Date Reported

**Have you notified your insurance provider?** Yes No

If yes, insurance company name:  Claim #:

Adjuster Name:  Adjuster Phone:    
Area Code Number

**To e-mail this form, please print, scan and then send as an attachment.**

**If we have questions about the information you have submitted, we will contact you directly. We expect to complete our assessment of your claim in 4-6 weeks, at which time we will advise you of the next steps in the process.**

BC Ferries is covered by the *Personal Information Privacy Act*. This information is collected for follow up on claims management and operational trend analysis and will only be used and disclosed for these purposes.

\_\_\_\_\_  
Claimant Signature \_\_\_\_\_  
Date Signed