NOTICE OF AN AT FAULT ACCIDENT DETERMINATION

The _____ (_____) Insurance Company hereby notifies the OPERATOR named below that an at-fault accident determination claim record is being reported to the Merit Rating Board. A determination has been made that the OPERATOR is more than 50% at fault for the accident described herein.

The at-fault accident may result in an increase in auto insurance premium in the future.

OPERATOR INFORMATION					
Name Address City, State Zip Telephone Number Email Address	Change of Address (enter corrections here) Address _____ City, State_____ Zip _____				
Date of Birth		Driver's License No.		State Code	

DO NOT APPEAL - If any of the above information is incorrect
Contact your insurance company to make the appropriate corrections.

ACCIDENT INFORMATION				
Accident Date	At Fault Accident Notice Date	Location Code	Policy No.	Claim No.

Standard of Fault Code		Explanation

INSURANCE AGENT		POLICYHOLDER (If different than the OPERATOR)		
Name Address City, State Zip				
		Date of Birth	Driver's License No.	State Code

AT FAULT ACCIDENT APPEAL INSTRUCTIONS

IF YOU BELIEVE YOU WERE NOT MORE THAN 50% AT FAULT IN THIS ACCIDENT AND WISH TO APPEAL TO THE MASSACHUSETTS DIVISION OF INSURANCE YOU SHOULD:

☐ Complete the Appeal Form on the reverse side of this notice. File only one appeal per accident. Include **BOTH** sides of this form.

☐ Send a check or money order for **$50.00 payable to the Commonwealth of Massachusetts**. The Division of insurance does not accept cash. A request for appeal must be submitted and received WITHIN 30 DAYS of the Notice Date.

☐ Return this completed form with the filing fee by Mail to:

DIVISION OF INSURANCE
P.O. BOX 370009
BOSTON, MA 02241-0709

***** DO NOT SUBMIT ADDITIONAL DOCUMENTS, PICTURES OR MATERIALS WITH THIS FORM *****
*****ORIGINALS WILL BE DESTROYED*****

All additional documents or materials must be presented at the time of the hearing.
The Division of Insurance will notify you as to the date, time, and location of your hearing.
Filing an appeal does not prevent an increase in premium for this at-fault accident. If an increase is billed, it must be paid. If it is later reversed, your premium will be adjusted, and the amount paid will be refunded or credited by the Insurance Company. Contact your insurance carrier or agent with questions regarding the surcharge.

Reasonable accommodations for people with disabilities are available upon request. Contact the Board of Appeal at least 14 days in advance of the virtual hearing date with a description of the accommodation you require. Send an email to boa.mailbox@state.ma.us or call 617 521-7478.

The OPERATOR should provide as much of the following accident information as possible: PLEASE PRINT

ACCIDENT INFORMATION

Time _____ ☐ AM ☐ PM Number of vehicles involved _____

Location _____ _____ _____ Number of lanes in each direction _____
CITY/TOWN STATE STREET

If intersection, intersection street _____ Number of lanes in each direction _____

Your speed prior to the accident _____ mph Posted speed _____ mph

SIGHT LINES/DISTANCE When you first saw the other vehicle, how far were you from it? _____

If a rear end collision, give distance between you and the vehicle you were following prior to accident _____

If an intersection collision, give your view in distance to right_____ to left_____ before entering the intersection.

POLICE at accident scene? ☐ NO ☐ YES Were you issued a citation ("ticket")? ☐ NO ☐ YES

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DAMAGE (example – passenger side rear door)

To the vehicle you were driving_____

To the other vehicle

BEFORE THE ACCIDENT YOUR CAR WAS √

☐ Going straight ahead	☐ Making a right turn	☐ Merging
☐ Starting from parked position	☐ Turning right on red	☐ Changing lanes
☐ Avoiding object in road	☐ Making a U-turn	☐ Overtaking another vehicle
☐ Starting from stop sign	☐ Stopped in traffic	☐ Backing
☐ Starting from traffic control	☐ Slowing or Stopping	☐ Other_____
☐ Making a left turn	☐ Parked	

LIGHT CONDITIONS √

☐ Dawn
☐ Daylight
☐ Dusk
☐ Dark - unlighted area
☐ Dark – Lighted area

TRAFFIC CONTROL √

☐ Traffic Light	☐ None
☐ Stop Sign	☐ Construction area
☐ Yield Sign	☐ Officer/Guard
☐ Flashing Light	☐ Other

ROADWAY SURFACE √

☐ Dry	☐ Sand
☐ Slush	☐ Mud
☐ Snow	☐ Wet
☐ Ice	

WEATHER √

☐ Clear	☐ Rain
☐ Cloudy	☐ Sleet
☐ Fog	☐ Snow
☐ Mist	☐ Other

PROVIDE DETAILS OF HOW THE ACCIDENT HAPPENED

_____

_____

_____

_____

_____

_____

_____

ACCIDENT DIAGRAM

STATE REASON(S) WHY YOU BELIEVE YOU ARE NOT MORE THAN 50% AT FAULT FOR THE ACCIDENT

_____

_____

_____

_____

I, the Operator named herein, being aggrieved by the determination of the issuing insurance company that I have been found to be more than 50% at fault for the accident identified in this AT FAULT ACCIDENT NOTICE do hereby appeal the insurance company's determination of fault in excess of 50%. I hereby declare the foregoing information and statements are made under the pains and penalties of perjury.

X_____ _____
OPERATOR'S SIGNATURE DATE

Mobile phone _____ Email address _____

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ALL ADDITIONAL DOCUMENTS OR MATERIALS MUST BE PRESENTED AT THE TIME OF THE HEARING