



MOTOR ACCIDENT CLAIM FORM

Company Name		Insurer and policy number.		VAT REGISTERED?	
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PARTICULARS OF INSURED VEHICLE

Registration No.		Make & Model		C..C.	
Mileage		Value	£	HP/Lease Details	
Owner of the Vehicle					

USE OF VEHICLE (The words Private, Business or Pleasure are not sufficient)

Use of vehicle at time of accident			
Was your seat belt being used by yourself?		By your passengers?	

DRIVER OF INSURED VEHICLE (These questions must be answered giving details of the driver or last user)

Name		Date of Birth		Occupation	
Address					
Details of any physical defect of infirmity, impaired sight or hearing			NONE		
Details of any driving offence convictions, including any pending					
Have you ever been refused insurance?		How long full licence held?	YEARS		
Details of any previous motor accidents					

OTHER PARTIES

Names and addresses of other parties involved and registration numbers of their vehicles		
What property was damaged? Generally, describe the damage and identify vehicle by make/registration no.		
What injuries were suffered and by whom?		
Third party's insurance details	Insurer name & address	
	Policy No.	

WITNESSES

Independent	

Travelling in insured's vehicle. (Give full no.)			
Did the Police witness the accident? If so, give details			
Did the Police attend & take any evidence of particulars? If so give details (including Police reference and address of station).			
Did the police advise they will be reporting you for any offence arising out of the accident?		If yes, give details	

DAMAGE TO THE INSURED'S VEHICLE

Give full particulars of damage (if any) to your vehicle			
Estimated cost of repairs. (Please forward estimate)		Name & Address of Repairers	
Is vehicle in use?		YES/NO	
If vehicle total loss, can we move it to avoid storage charges? If yes, please remove personal effects		YES/NO	
Will you be claiming under the terms of your policy for any damage caused to your vehicle, if covered?		YES/NO	
Can you please confirm the location of your vehicle at present?			

CIRCUMSTANCES OF ACCIDENT

Date of Accident		Exact Location of Accident			
Time (am/pm)		Town		County	
State speed Limit		State width of road		Weather conditions	
Conditions of road					
Was your vehicle on the near-side of the road		YES/NO		If yes, how far from kerb?	
				If no, on what part of the road was it?	
Did your driver give a warning and how?				Did the driver of the vehicle (if any) give warning and how?	

If the accident occurred after lighting up time, was:

Your vehicle lighted and how?		The other vehicle lighted and how?	
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What was the speed of your vehicle?

Immediately before the impact?		At the moment of impact?	
Were you breathalysed?		NO	
State result		If positive, state level of alcohol	

GIVE A FULL DESCRIPTION OF EXACTLY HOW THE ACCIDENT OCCURRED

Do you consider you were responsible for the accident?	YES/NO
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Signature of INSURED..... & Driver (if not the insured).....

Date.....

**WHEN SENDING THE CLAIM FORM PLEASE ENCLOSE A COPY OF THE DRIVERS LICENCE.
THE INSURER NEEDS THIS TO VALIDATE THE CLAIM.**

SKETCH OF ACCIDENT