

MOTOR VEHICLE ACCIDENT CLAIM FORM

POLICY HOLDER	
Name	Policy/Certificate No.
Address	Daytime Phone No
Postcode	Occupation
Are you registered under the VAT regulations? YES <input type="checkbox"/> NO <input type="checkbox"/>	
If YES , please give details	

DRIVER (or person in charge of vehicle)	
Name (Mr/Mrs/Miss)	Daytime Phone No.
Permanent Address	
Date of Birth	Occupation
How long employed by you?	Current Licence No. (State if provisional)
Date of First Full Licence	Is the driver the main user? <input type="checkbox"/> YES <input type="checkbox"/> NO
If NO , give proportion of use <input style="width: 50px;" type="text"/>	
If <i>not the Policyholder</i> , did the driver have the Policyholder's permission to drive? <input type="checkbox"/> YES <input type="checkbox"/> NO	
And does the driver own a motor vehicle? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES , give the name and address of Insurer and number of Motor Policy	
Has the driver:-	
1. been concerned in any accident or loss during past three years?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. ever been prosecuted or incurred a Fixed Penalty for an endorsable offence in connection with a motor vehicle?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. ever been declined or refused renewal for vehicle insurance?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. any physical defect, infirmity or impairment of sight or hearing?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If answer to question 1,2,3 or 4 is YES , give details	

INSURED VEHICLE	
Make	Model Reg. No
Year of Manufacture	Name of H.P. Company or Finance House interested (if any)
Description of Damage	
Repairer's Name, Address and Tel No.	
Is Vehicle at Repairer's Premises? YES <input type="checkbox"/> NO <input type="checkbox"/> Estimated cost of repair (if known)£	
Purpose for which vehicle was being used	
Number of persons being carried (including the driver)	Nature of goods being carried (if any)

THIRD PARTY				
Name	Tel No. (Home)			
Address	(Office)			
Name of Insurers				
Policy/Certificate No.	Make and Model of Vehicle			
Registration No.				
Description of damage to other Vehicle or Property				
Injured Persons:				
Name	Address	Nature of injuries sustained	Apparent age	State whether occupant of Insured Car, other car, or pedestrian

Particulars of Hospital or Doctor attending injured person(s):

ACCIDENT		
Date	Time	Place
State of Roads	Weather conditions	

Give sketch plan of accident here

Show if possible, widths of roads, location and direction of travel of vehicles

Or pedestrians concerned and relevant road signs

INSURERS AND THEIR AGENTS SHARE INFORMATION WITH EACH OTHER TO PREVENT FRAUDULENT CLAIMS AND TO DECIDE WHETHER TO ACCEPT YOUR PROPOSAL AND, IF SO, ON WHAT TERMS VIA THE CLAIMS AND UNDERWRITING EXCHANGE REGISTER, OPERATED BY INSURANCE DATABASE SERVICES LTD. A LIST OF PARTICIPANTS IS AVAILABLE ON REQUEST. THE INFORMATION YOU SUPPLY ON THIS FORM, TOGETHER WITH THE INFORMATION YOU HAVE SUPPLIED ON YOUR APPLICATION FORM AND OTHER INFORMATION RELATING TO THIS CLAIM, WILL BE PROVIDED TO PARTICIPANTS.

I/We declare the foregoing particulars to be correct according to my information and belief. I/We understand that you may seek information from other insurers to check the answers I/We have provided. This report is made in the bona fide belief that litigation may ensue and to enable solicitors and/or agents to conduct such litigation and advice in relation thereto

Signature of Policyholder	Date
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