MOTOR INSURANCE
CLAIM FORM

Please return this form as soon as possible and in a maximum of 15 days from the date of accident. Do not start any repairs prior to our official approval.

The information required in this form is sought in the bona fide belief that litigation may ensue and for the purpose of furnishing to the solicitors of the Company information enabling them to advise us on behalf of the Insured.

Policy No : ..... Period of insurance : From ..... To .....

Terms of insurance : ..... Insured value : ..... Excess, if any : .....

INSURED

Name : .....

Address : .....

Telephone : (M) ..... (O) ..... (H) .....

Email address : ..... Business Registration Number : .....

VEHICLE

Registration number : ..... Make and Model : .....

Year : ..... Type of Body : .....

DRIVER

Name : .....

Address : ..... Date of birth : .....

..... Driving Experience : Years ..... Months .....

Driving Licence No : ..... Telephone : .....

Have you been prosecuted for any motoring offences? Yes__ No__ If so, when : .....

Are you in the Insured's employment? Yes__ No__ If so, in what capacity and for how long? .....

If you are not the insured; what is your relationship with insured : .....

PURPOSE OF USE AT TIME OF ACCIDENT

For what purpose was the vehicle being used? .....

If used for the carriage of goods or passengers, please provide the following details:

Class of licence held : ..... Usual capacity of the vehicle : .....

Load at time of accident : .....

PARTICULARS OF ACCIDENT

Date : ..... Time : ..... Place : .....

State of weather : ..... What was the condition of the road? .....

Were any traffic lights in operation at scene of accident? If so, were they in your favour? Yes__ No__

Was your vehicle on the main road? Yes__ No__ What was the approximate speed of your vehicle? .....

Has the driver been subject to any alcohol or drugs test (either blood, urine or breath) in connection with the accident? Yes__ No__

If yes, please give details

.....

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PARTICULARS OF ACCIDENT *continued*

Was an Agreed Statement of Facts completed after the accident? Yes ___ No ___

Taking into account the circumstances of the accident, do you believe you are at fault? Yes ___ No ___

If the accident was reported to the Police, please state which Police Station : .....

Please give full description of the accident and events leading up to the accident :

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DIAGRAM OF SCENE OF ACCIDENT

Please provide a SKETCH showing by arrows the respective directions of vehicles and/or persons involved in the accident and indicate the position of any nearby pedestrian crossing and/or traffic signs

DAMAGE TO INSURED VEHICLE

If your vehicle has been damaged, please provide details of the visible damage:.....

.....

From which garage have you requested an estimate of repairs? .....

DETAILS OF THIRD PARTY

Name : .....

Address : .....

Telephone : (M) ..... (H) .....

Insurer's Name : ..... Vehicle registration number : .....

Make and Model : ..... For what purpose was the vehicle being used? .....

Please provide details of the visible damage on the third party vehicle : .....

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WITNESSES OF ACCIDENT

Please state full names and contact details of persons who were travelling in your vehicle at time of accident :
(Name/Phone numbers/Email address)

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Independent witness :

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If any person received treatment at the scene of the accident or was taken to the hospital, please provide the names and contact details of the injured persons, of the attending doctor, and the hospital.....

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DECLARATION

I/We hereby declare that the above statements and facts are true and that I/We have not withheld from the Company any information which is to my/our knowledge connected with the accident.

Date: ..... Driver's Signature: .....

Date: ..... Insured's Signature: .....