



MOTOR ACCIDENT REPORT FORM

Section 1 - Please complete in all cases

Policy Number	<input type="text"/>	Date of Accident	<input type="text"/>
Vehicle Registration	<input type="text"/>	Time of Accident	<input type="text" value="AM / PM"/>
Policyholder Full Name	<input type="text" value="Mr/Mrs/Miss/Ms/title"/>		
Present Address	<input type="text"/> <input type="text"/> <input type="text" value="Postcode"/>		
Telephone number	<input type="text" value="Home"/>	<input type="text" value="Business/Mobile"/>	
Date of Birth	<input type="text"/>		
Is a full driving licence held?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If 'yes' date driving test passed <input type="text"/>
Occupation (s)	<input type="text" value="Full time"/>	<input type="text" value="Part time"/>	
Is the insured registered for VAT?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is the vehicle owner registered for VAT? Yes <input type="checkbox"/> No <input type="checkbox"/>
Details of any previous accidents or Losses sustained in connection with a motor vehicle. If None, please state none	<input type="text" value="Dates"/>	<input type="text" value="Circumstances"/>	
Details of all motoring convictions <i>Including fixed penalties</i> and any pending prosecutions. If None, please state none	<input type="text" value="Date of conviction"/>	<input type="text" value="Offence/offence code"/>	<input type="text" value="Sentence/fine"/>
Details of all other criminal convictions involving fraud or dishonesty e.g. <i>shoplifting, arson</i> If none, please state none	<input type="text"/>		

Section 2 – Person Driving or LAST in charge of vehicle

Was the Policyholder driving or last in charge of the vehicle at the time of the Accident ?

Yes

If Yes' please go straight to Section 3

No

If 'No' please complete Section 2 below and then go to Section 3

Person Driving or LAST in charge of vehicle

Full Name

Mr/Mrs/Miss/Ms/title

Present Address

Postcode

Telephone number

Home

Business/Mobile

Date of Birth

Occupation(s)

Full time

Part time

Details of any previous accidents or Losses sustained in connection with a motor vehicle.

If None, please state none

Date

Circumstances

Details of all motoring convictions Including fixed penalties and any pending prosecutions.

If none, please state none

Date of conviction

Offence/offence code

Sentence/fine

Details of **all** other criminal convictions involving fraud or dishonesty e.g. *shoplifting, arson*
If none, please state none

How often does this person use the vehicle?

daily

weekly

monthly

other

please state

What is the person's relationship to the insured? e.g. *employee, son, daughter etc*

Does this person have insurance of their own?

Yes

No

If 'Yes' please give Name of insurer and Policy No.

Insurer

Policy No.

Is a full driving licence held?

Yes

No

if 'Yes' date driving test passed

Section 3 – Your Vehicle Details - Please complete in All cases

Vehicle Make	Model	Colour
<input type="text"/>	<input type="text"/>	<input type="text"/>
GVW <i>commercial vehicles only</i>	Cubic Capacity	Engine number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Chassis/VIN number	Year of Manufacture	Mileage at date of Accident/Theft
<input type="text"/>	<input type="text"/>	<input type="text"/>
Is the Policyholder the Main User of the Vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/> If 'no' please state who is below	
	<input type="text"/>	
Is there any outstanding finance or hire purchase on the vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes please give name and address of the company below.	
	<input type="text"/>	
Is the Policyholder the legal owner of the vehicle <i>and/or trailer?</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> If, no please explain why and give name and address of registered owner	
	<input type="text"/>	
Please give details of any alternations/modifications made to the vehicle	<input type="text"/>	
	<input type="text"/>	
Is the vehicle still driveable?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
What is the extent of the damage	<input type="text"/>	
Where and when can the vehicle be inspected?	<input type="text"/>	
Repair estimate attached?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
In the event of your vehicle being uneconomical to repair, may we move it to a place of free storage in order to minimise storage charges?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Section 4 – About the Accident

Exact location where Accident occurred (eg Road Name, Town or Parish)

Please give full details of how the accident happened? It is helpful if you describe speed, signals given by all parties and weather conditions.

Please draw a diagram or sketch of the vehicle(s) in the accident. Please try to show road markings, traffic lights, approximate road widths etc.

What was the vehicle being used for, where was it going?

Did the Police attend the accident? Yes No If 'Yes' give details of Officer's Name & Police Force/Station

Were there any witnesses? Yes No not applicable

Name Address/Telephone Number

If 'yes' please give their names and contact address/telephone

1)
2)

Were any other people involved in the accident? Please give as much information as you can about any injuries & their damage.

Name, Address and Telephone No.	Vehicle Registration	Insurers/Policy No	Details of injury	Their Damage

Do you hold any of the above responsible Yes No If 'Yes' please state why
for the accident?

Section 5 - Declaration

I/We declare that the details given on the claim form are true and complete to the best of my/our knowledge and belief. I/We understand that if any claim is in any respect fraudulent or if any fraudulent means including inflation or exaggeration of the claim are used to obtain benefit, all benefit under the policy shall be forfeited and criminal proceedings may ensue.

Signed

Date