

Please complete this form clearly and in BLOCK CAPITALS. Please use a separate sheet of paper if there is insufficient space on this form



## Motor Vehicle Accident Claim Form

### Details of Policyholder

Name:	(Mr,Mrs,Miss,Ms)	Policy Number:
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Address:	Tel No. Home:
	Tel No. Business:
	E-Mail:

Occupation / Business:
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### Vehicle Use

Make/Model:	Registration Number:
Year of manufacture:	Engine size / GVW:
Who is the owner of the Vehicle?	For what purpose was the vehicle being used?

### Particulars of Driver

Name:	(Mr,Mrs,Miss,Ms)	Date of Birth:
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Address:	Date passed driving test:
	Type of licence held: Full / Provisional / HGV / PSV (Delete as appropriate)
	Permitted Groups:

Has driver (a) been convicted of any driving or motoring offence within the last 5 years or is a prosecution pending? Yes / No
If "Yes", please give full details including the date, offence code & penalty points
(b) been involved in an accident during the last 5 years? Yes / No
If "Yes", please give details

### Details of Damage to the Policyholder's Vehicle

Details of damage:
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Is the vehicle still in use? Yes / No			
Where can the engineer inspect your vehicle:			
Are you registered for V.A.T. Yes / No		What percentage can you recover?	%

Please give the name(s) and address(s) of any independent witnesses

**Circumstances of the Accident**

Date:	Time:	am/pm	Speed:
Location:			
Weather Conditions:			
Do you feel you (or the driver of your vehicle at the relevant time) was responsible for the accident? Yes / No / Partially			
Did the Police attend? Yes / No			
Have the Police issued a notice of intended prosecution or given a verbal warning or caution? Yes / No			
If "Yes", to whom and for what alleged offence?			

**Give details of what happend**

Please provide an explanatory sketch of the incident

**Particulars of Other Parties involved & Property Damaged**

Name & Address of owners and, if appropriate, driver	Make / Model / Reg No.	Insurers Name, Address & Policy No.	Apparent Damage

**Details of Injured Persons**

Name	Address	Nature of Injuries	State whether occupant of insured car, other car or pedestrian

I/We hereby declare that the information given is true to the best of my/our knowledge and belief

Policyholders Signature:

Print name:

Date:

Position:

Drivers Signature: