

# MOTOR INCIDENT REPORT FORM

Claim number

## Completing your form

We recognise the need for prompt and careful handling of your claim. Please help us to help you by answering all relevant questions. Continue your answers on a separate page if necessary and if completing by hand, please use block capitals.

It is a condition of the policy that all claims **must** be reported regardless of damage or fault.

### In addition you should:

- note that insurers have deadlines for submitting claim forms so do not delay returning this form. If the claim form is submitted late, insurers may decline your claim;
- telephone us on 020 8329 4900 if you need assistance with completing this form;
- do not admit liability or respond to any third party correspondence;
- provide all documentation in support including photographs of the damage;
- This claim will only be accepted if signed by the Policyholder or their authorised representative.

## 1. INSURED

Insured Name:	<input type="text"/>
Policy Number:	<input type="text"/>
Correspondence address:	<input type="text"/>
Telephone Number:	<input type="text"/>
Fax Number:	<input type="text"/>
Email address:	<input type="text"/>
Are you the:	<input type="checkbox"/> Owner <input type="checkbox"/> Tenant <input type="checkbox"/> Agent
Business/occupation:	<input type="text"/>
Are you VAT registered?	<input type="text"/>

Please provide the details of who we should contact regarding this matter if it is not the Policyholder. Please note that this person must be authorised by the Policyholder to discuss this incident on their behalf.

Name:	<input type="text"/>
Position/title:	<input type="text"/>
Telephone number:	<input type="text"/>
Email address:	<input type="text"/>

## 2. INSURED VEHICLE

Registration Number:	<input type="text"/>
Cubic Capacity:	<input type="text"/>
Colour, make and model:	<input type="text"/>
Is the vehicle still in use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Description of damage:	<input type="text"/>
Where is the vehicle?	<input type="text"/>
Have you obtained a quote for repairs?	<input type="text"/>
Are you the owner of the vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 3. INSURED DRIVER

Name:	<input type="text"/>						
Address:	<input type="text"/>						
Date of birth:	<input type="text"/>						
Occupation:	<input type="text"/>						
Employer:	<input type="text"/>						
Date UK Test Passed:	<input type="text"/>						
Does the driver have:	<table><tr><td>Any disabilities?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td>Any convictions?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr><tr><td>Any accidents in the past 5 years?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr></table>	Any disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any convictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any accidents in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any disabilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Any convictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Any accidents in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No						

If you answered "yes" to the above question, please provide details here:

## 4. INCIDENT DETAILS

Date and time of incident:	<table><tr><td>Date:</td><td><input type="text"/></td><td>Time:</td><td><input type="text"/></td></tr></table>	Date:	<input type="text"/>	Time:	<input type="text"/>
Date:	<input type="text"/>	Time:	<input type="text"/>		
Details of incident:	<input type="text"/>				
Purpose of journey:	<input type="text"/>				
Who in your opinion is to blame?	<input type="text"/>				

#### 4. INCIDENT DETAILS / Continued

Were there any:

Passengers?

Yes  No

Injuries?

Yes  No

Witnesses?

Yes  No

If you answered "yes" to the above question, please provide names and addresses below.

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Did the Police witness the incident?

Yes  No

Did the Police take details?

Yes  No

If yes, please provide the Crime Reference Number:

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Have you received any notice of prosecution?

Yes  No

Was there a third party involved?

Yes  No

If you answered "yes" to the above question, please complete section 5. If not, go straight to section 6.

#### 5. THIRD PARTY DETAILS

Registration number:

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Name:

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Address:

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Telephone number:

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Colour, make and model:

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Policy number:

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Insurer:

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Have you received an notice of claim against you?

Yes  No

#### 6. PLEASE PROVIDE A DIAGRAM OF THE INCIDENT

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## 7. DRIVER'S STATEMENT

## 8. DATA PROTECTION ACT

By signing this claim form you consent to Clear Insurance Management and the Insurers of the mentioned Policy using the information we may hold about you for the purpose of handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information and criminal convictions). This may mean we have to give some details to third parties involved in the claims process. These may include adjusters, fraud detection and prevention services, insurers, re-insurers and insurance regulatory authorities. Where such sensitive personal information relates to anyone other than you, you must obtain explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies changed.

## 9. DECLARATION

I declare that the details given on this form are true and complete and to the best of my knowledge.

Name:

Signature:

Date: