MOTOR ACCIDENT REPORT FORM

IMPORTANT NOTICE
1. No Liability is admitted by issue of this Form.
2. Neither owner nor driver may admit fault or Liability for this Accident.
3. Do not answer communications about this Accident.
   Direct these to the Insurance Company for Action.
4. All questions on this form must be answered.
5. Repairs must not be authorised without prior authority of the Insurance Company.

INSURED
Name_________________________Tel.No_________________________
Address_____________________________________________________

BUSINESS/OCCUPATION

POLICY
Number__________________Expiry Date___________________________
Name of hire purchase or finance company_________________________

VEHICLE
Make & Model_________________________HP/CC_____________________
Reg. No. of vehicle________________Carrying capacity_______________
Reg. No. of trailer________________Carrying capacity_______________
Name and Address of owner______________________________

USE
State the exact purpose for which the vehicle was being used at the time of the accident

COMMERCIAL VEHICLES
Description of goods being carried_______________________________
Name of owner of goods____________Was a trailer attached?_______
Weight of load on (a) Vehicle____________(b) Trailer(S)__________

DRIVER
Name_________________________Occupation_______________________
Address_________________________Tel. No_________________________

Is he employed by you?_________________________How long has he been in your service?________
Was he driving with your permission?_____________How long has he been driving motor vehicles?________
Was he in any way to blame for the accident?__________Did he admit liability?__________
Has he had any previous accidents?__________If so, how many, and approximate date?________

Has he any conviction for any offence in connection with any motor vehicle or any charges pending?
If so, details including dates____________________________________

Does he hold a full or provisional licence to drive this vehicle?________
If full, state date when driving test first passed_____________________
Number_________________________
Does he own a Motor Vehicle?____________if so, give name and address of Insurer
Driver’s Policy No_________________________

ACCIDENT
Date_________________________Time_________________________
a.m./p.m.Place______________________________
Type of Road surface________________Visibility________________Wet or Dry?
What lights were showing on your Vehicle?_________________________
What warning did your driver give?_______________________________
Estimate speed before accident____________________Weather conditions__________
Did Police take particulars?__________If so, give Constable’s number and station________

To which Police Station was the accident reported?
Attach copy Notice of Intended prosecution if any.

CL/MV/029
PLAN OF ACCIDENT

Draw sketch (stating approximate measurements) showing position of vehicles and persons concerned and the direction in which they were travelling. Also show type and position of traffic signs, skid marks, pedestrian crossings and any other relevant information.

STATEMENT BY DRIVER

Signature of Driver

STATEMENT BY OWNER OR INSURED

DAMAGE TO INSURED VEHICLE

State briefly apparent damage.

(In all cases where your vehicle is damaged and you are entitled to claim under your policy, please send at once to the Company an estimate for repairs).

Repairer’s name and address

Tel. No.

Is the vehicle still in use? When and where can it be inspected?

OTHER VEHICLES INVOLVED AND PROPERTY DAMAGED

Name and address of owner | Reg.No. | Name of Insurer | other property damaged

Name and address of driver:

PERSONS INJURED

Name and address | Relationship to the Insured | If Driver or Passenger Reg.No. of vehicle | Apparent injuries

INDEPENDENT WITNESSES

Name | Address

PASSENGERS IN YOUR VEHICLE

Name | Address

I DECLARE that these particulars are true and correct and undertake to forward immediately (and unanswered) any correspondence relating to this accident.

Date | Signature of Insured