# Motor Incident Claim Form

Please complete this form fully; it is a condition of your policy to report all incidents as soon as possible even if you do not intend to make a claim.

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| **Insured’s Details** | **Date Form Completed –**  |
| Company Name:  |  |
| Policy Number:  |  |
| Address (Main Office): |  |
| Address (Branch Office)  |  |
| Driver Details - Perm/PT/Agency: |  |
| VAT Registered and No. if applicable:  |  |
| Tel :  |  |
| Fax:  |  |
| Email:  |  |
| **Driver/Last person to use** |  |
| Name: |  |
| Address: |  |
| Date of Birth: |  |
| Date of employment with company:  |  |
| Previous accidents/claims/losses: |  |
| Licence Type and class: |  |
| Date passed test (inc. HGV if applicable): **Please Complete** |  |
| Previous convictions:  |  |
| Any medical conditions reportable to DVLA: |  |
| **Vehicle Details** |  |
| Make:  |  |
| Model:  |  |
| Registration: **Please Complete** |  |
| Tonnage: |  |
| Special features/adaptions: |  |
| Current location:  |  |
| Point of impact:  |  |
| Damage description: |  |
| Driveable/ Undriveable: |  |
| **Finance Details** |  |
| HP Company: |  |
| Address:  |  |
| Agreement Number:  |  |
| Telephone Number:  |  |
| **Incident Details** |  |
| Accident date and time:  |  |
| Incident type:  |  |
| Precise location:  |  |
| Police reference:  |  |
| Police details: |  |
| Purpose of journey:  |  |
| Speed:  |  |
| **Passengers in Insured’s vehicle** |  |
| Name, address and relationship to insured/driver : |  |
| Name, address and relationship to insured/driver: |  |
| Name, address and relationship to insured/driver: |  |
| **Injured persons** |  |
| Name, address and relationship to insured/driver: |  |
| Name, address and relationship to insured/driver: |  |
| Name, address and relationship to insured/driver: |  |
| **Third Parties:** |  |
| Name:  |  |
| Address: |  |
| Telephone Number:  |  |
| Mobile Number: |  |
| Work Number:  |  |
| Registration: **Please Complete** |  |
| Damage Description:  |  |
| Number of passengers in third party vehicle |  |
| **Witness** |  |
| Name:  |  |
| Address:  |  |
| Telephone Number:  |  |
| Mobile number:  |  |
| Independent:  |  |
| **Footage/CCTV** |  |
| Vehicle/Cab footage available? |  |
| Was there any public or private CCTV overlooking the incident? (if yes, please provide details) |  |

# Incident Description and Diagram:

Please give details of exactly how the incident happened and provide a diagram in the space provided. If the vehicle was carrying goods or cargo, please specify the contents. If the vehicle was hit whilst parked or stolen, please identify the last person to be in charge of the vehicle

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Does driver feel at fault for this accident: Yes/No

Policyholder’s or Company Official’s Signature…………………………………………….Date………………………….