



## MOTOR VEHICLE ACCIDENT CLAIM FORM

The issuing of this Form is not an admission of liability by the Company. All questions must be fully answered.

Claim No.	Policy No.
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Type of Cover	Policy Period
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### Policyholder

Name & Surname	ID No.
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Address	Tel No.
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Mob No.
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Email Address	Occupation
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VAT Reg No.	VAT Status
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### Driver

Name & Surname	ID No.
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Address	Tel No.
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Mob No.
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Email Address	Date of Birth
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Licence No.	Date of Expiry	Licence Group
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Relationship to Policyholder	Occupation
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Was driver using vehicle with policyholder's permission?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Details of Previous Accidents
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### Vehicle

Reg No.	Make & Model	Year of Manufacture
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Is the vehicle subject to a Hire Purchase Agreement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If <b>Yes</b> give full details and address
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### Particulars of Accident

Date / /	Time <input type="checkbox"/> am <input type="checkbox"/> pm	Vehicle Use: Business <input type="checkbox"/> Private <input type="checkbox"/>
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Location
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Estimated speed of vehicle at time of accident	<input type="checkbox"/> KPH	<input type="checkbox"/> MPH
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Accident was reported to:	<input type="checkbox"/> Wardens	<input type="checkbox"/> Police	Report No.	<input type="checkbox"/> Front to Rear
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State of road / road surface	<input type="checkbox"/> Smooth	<input type="checkbox"/> Rough	<input type="checkbox"/> Wet	<input type="checkbox"/> Dry	<input type="checkbox"/> Uphill	<input type="checkbox"/> Downhill	<input type="checkbox"/> Flat
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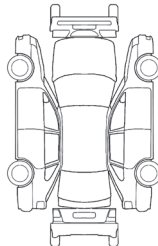
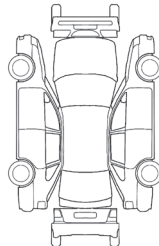
Were seatbelts being worn by:	<input type="checkbox"/> Driver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Passenger	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Name & Addresses of passengers / witnesses
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How did the accident or theft happen?
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Who do you consider was at fault?	<input type="checkbox"/> Myself	<input type="checkbox"/> Other Driver	<input type="checkbox"/> Both	<input type="checkbox"/> Other Party
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**Sketch Plan of Accident**

Please draw a plan of the accident showing scene of accident, road widths, road signs and position of vehicles. Indicate with arrow the direction in which the vehicles were travelling	Show the damaged areas to Your / Third Party vehicle on the following diagrams	
	Your Vehicle 	Third Party Vehicle 

**Third Party Damage**

	Third Party 1	Third Party 2	Third Party 3
Name & Surname			
Id No.			
Address			
Tel No.			
Reg No.			
Make/Model			
Damages			
Insurer			
Repairer			
Survey Date			

**Personal Injuries**

Name	Type of Injury	Injured Party	Vehicle Reg No.

**Important Note**

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form together with other information relating to the claim, may be provided to other Insurers, their Agents and Insurance Associations

**Privacy Policy**

Middlesea Insurance plc deems it important to protect your right to privacy. Any personal information that you provide to Middlesea Insurance plc shall be processed in accordance with the Data Protection Act 2001 and the Professional Secrecy Act 1994

**Declaration**

I/We declare that the information given in this form is true and correct to the best of my/our knowledge & belief

Insured's Signature \_\_\_\_\_

Driver's Signature \_\_\_\_\_

Date \_\_\_\_\_