



# MOTOR ACCIDENT REPORT

(NOT FOR USE ON THEFT CLAIMS OR MOTOR TRADE)

Policyholder's Name

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Company Name

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Policy No.

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Cover Applicable

Comprehensive

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Third Party Fire & Theft

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Third party only

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Broker/Agent (if applicable)

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## IMPORTANT

We wish to process your claim as quickly as possible. Therefore please ensure:-

- All questions are fully answered
- All required documents are enclosed
- A copy of the drivers licence must accompany this form
- Return completed form to Tradex Insurance Company Limited, 7 Selsdon Way, London E14 9GL

**Failure to do so will delay the claim. If in doubt please telephone our First Response Claims Line.**

**First Response Claims Line** 0845 373 1300 • **Fax** 020 7068 7740 • **Email** firstresponse@tradex.com • **www.tradex.com**

**PLEASE ANSWER EVERY QUESTION FULLY. FAILURE TO DO SO COULD RESULT IN DELAY.**

## 1 POLICYHOLDER'S DETAILS

Full Name		Date of Birth
Address		Post Code
Home Telephone	Mobile	
Business Telephone	Email	
Occupation (including any part time occupation)		
Are you registered for VAT <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>		
VAT Status	Full / Partial recovery	VAT Number

## 2 DETAILS OF DRIVER (or last person to drive before the incident)

Full Name		Date of Birth
Address (Private)		Post Code
Home Telephone	Mobile	
Business Telephone	Email	
Full Time Occupation	Part Time Occupation	
Driving Licence Number	Licence Expiry Date	Date UK Test Passed
Type of Licence	Full UK <input type="checkbox"/> Provisional <input type="checkbox"/> HGV <input type="checkbox"/> PSV <input type="checkbox"/>	Other (state nationality)
Was the vehicle being used with Policyholder's consent		Yes <input type="checkbox"/> No <input type="checkbox"/>
If not the Policyholder driving, does the driver have his own insurance		Yes <input type="checkbox"/> No <input type="checkbox"/>
If YES, give details of insurers		Policy No

### Relationship of driver to Policyholder if other than Self (tick as appropriate)

Spouse  Child  Parent  Friend  Employee  Other (please specify)

Have you as Policyholder or the driver ever been convicted of any offence or received a fixed penalty notice Yes  No

Have you as Policyholder or the driver ever been involved in an accident Yes  No

Have you as Policyholder or the driver ever been involved in any other claim or incident in connection with a motor vehicle Yes  No

Have you as Policyholder or the driver ever been refused insurance or had any insurance cancelled or been refused renewal Yes  No

Have you ever suffered from any physical or mental disability Yes  No

If the answer to any of the questions above is YES, please give full details overleaf. Use a separate sheet if necessary.

## 2 CONTINUED

Date	Driver	Circumstances/Details	Conviction Code	Fine

Physical/Mental disability

## 3 DETAILS OF INSURED VEHICLE OR VEHICLE BEING DRIVEN AT THE TIME

Registration Number	Year of Make	Make and Exact Model	Colour	CC (or GVW if CV)	Mileage if Known	Current Value

Is the vehicle owned by the Policyholder Yes  No

Is the vehicle registered in the Policyholder's name Yes  No

If the answer to either of the above questions is NO, give full details of the owner / keeper and relationship to owner / keeper

Date of purchase

Purchase price £

Has the vehicle been modified in any way Yes  No

If YES, give details

Is the vehicle subject to Hire Purchase or Lease Yes  No

If YES, give full name and address of Finance / Leasing Company

Post Code

Telephone No

HP Agreement No / Lease Contract No

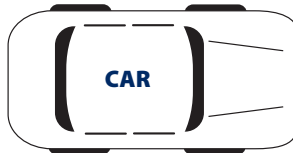
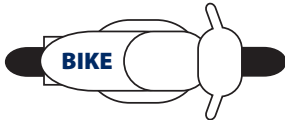
**Note: In the event of a total loss, settlement of the claim will be paid to the Finance / Leasing Company. If the finance figure is less than our total liability, then the remaining sum will be sent to the policyholder.**

## 4 DETAILS OF DAMAGE

Describe the damage to your vehicle

Show area of impact thus **x x x**

**FRONT** →



Estimated repair cost £

Is the vehicle at the repairer's now

Yes  No

If NO, where is it

Repairer's Name

Repairer's Telephone Number

Repairer's Fax Number

Repairer's Address

Post Code

Have you attached an estimate to this form

Yes  No

Are you satisfied that the repairer's you have chosen are capable of carrying out your repair expeditiously and to your satisfaction

Yes  No

If NO, do you have another repairer you would prefer

## 5 DETAILS OF EXACT USE OF THE VEHICLE

Please state EXACT USE of vehicle (if vehicle was not being driven, then state use prior to parking and the journey destination)

**Please Note: 'Social / Pleasure' are not adequate explanations, a detailed description of journey and usage is required.**

Name(s) of passenger(s) carried and approximate ages (yrs)

Were any goods being carried

Yes  No

If YES, weight of load

## 6 DETAILS OF ACCIDENT

Date	Time	Weather Conditions	Road Conditions
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Exact location (Road, Town / County)

Speed limit	Width of road
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	Your Vehicle	Third Party Vehicle (if applicable)
<b>Speed of vehicle prior to accident</b>		
<b>Distance from nearside kerb</b>		
<b>What lights were displayed</b>		
<b>What signals were given</b>		
<b>What warnings were given</b>		

Briefly state in your opinion who was to blame and reason(s)

Describe fully how the accident occurred

SKETCH PLAN Please draw a sketch of the road(s) showing the position of the vehicles at the point of impact. Indicate directions by arrows. Please show road signs/markings and directions of nearest towns.

Show your vehicle as

	<b>1</b>	
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## 7 DETAILS OF OTHER VEHICLES OR PERSONS INVOLVED (USE EXTRA SHEET IF NECESSARY)

Make and Registration Number of Vehicle	Name and Address of Owner and or Driver	Details of Insurers / Policy number	Damage to their Vehicle	No of Occupants in Vehicle

### Witnesses

Name and Address of Own Passengers	Name and Address of Any Other Witnesses

Was the accident reported to the Police      Yes     No

If YES, what was the Reporting Officers Name and Number

Police station (with address)

Any prosecution likely      Yes     No

If YES, give full details and against whom

Was any person breathalysed    Yes     No     If YES, whom     Result of test      Positive     Negative

Was any person injured      Yes     No     If YES, whom    Own Passengers     TP Occupants     Pedestrian     Pedal Cyclist

Give details overleaf

## 7 CONTINUED

Brief description of person injured (ie female front passenger complaining of concussion)	Approx Age	Nature of Injuries	Seat Belt Worn Yes/No

Was any person taken to Hospital      Yes\*  No       Do you know if they were detained      Yes  No       Has any claim been made against you      Yes  No

\*If YES, Name and Address of Hospital

**Note: If the vehicle has been confirmed a 'total loss' by our engineer, we will move it to our own nominated storage depot for safe keeping whilst settlement proceeds. Such steps are not to be taken as an admission that any liability attaches under the policy. It is your duty to safeguard the vehicle from any further damage following the accident and not to abandon it.**

**Any claim against you, including any communication from the police or from any hospital authority, must be passed to us immediately without acknowledgement**

## 8 SETTLEMENT OF TOTAL LOSS CLAIMS

In the event of a total loss we will appoint an independent assessor to investigate the loss and to impartially assess the value of the vehicle. When settlement has been agreed we shall pay the amount(s) due less any policy excesses, premiums outstanding or finance on the vehicle by cheque or electronic transfer direct to your bank account, so please give your bank details below:

Name of Bank       Branch       Sort Code

Account Number       Account Name

If the account is NOT in the name of the Policyholder, please state relationship between Policyholder and account holder to be credited

## DECLARATION (Please read before signing)

I/We declare that the above statements are true and correct to the best of my/our knowledge and belief. I/We hold no other policy in addition to this one indemnifying me in respect of this claim. I/We have not withheld from the Insurers any information within my knowledge connected with the loss and I/we agree to provide the Insurers with any further information or documentation as may be required. If my/our vehicle is a total loss I/we agree that the company have my permission to remove the vehicle to safe and free storage pending the completion of their investigations and any settlement of this claim. I/We understand that any attempt to make a fraudulent accident claim will result in prosecution.

Signature of Driver or Last Person in Charge of Vehicle \_\_\_\_\_ Date \_\_\_\_\_

Signature of Policy Holder \_\_\_\_\_ Date \_\_\_\_\_

If this form has been compiled by another party on behalf of the Policyholder, will the compiler please complete the section below.

Name       Occupation

Address   
 Post Code

## DOCUMENTS REQUIRED

1 This Claim Form

2 Copy of Driver's Licence (good photocopy)

3 Policy Number

4 Repair estimates if claiming for own damage (two competitive estimates if possible)

### In Addition for total loss claim

5 Vehicle Registration Book

6 MOT Certificate

7 Vehicle Keys

8 Purchase receipt for vehicle

9 Any documents to establish value & condition of vehicle

10 Photographs of vehicle if available