



Motor Accident Report



Motor Accident Report Form

INSURED

Name

Address

Occupation

Policy No.

Home Tel. No.

Work Tel. No.

Mobile

Email

VAT Registered: Yes No Partial

DRIVER

Name

Address

Occupation

Date of Birth

Home Tel. No.

Work Tel. No.

Was driver in insureds employ at time of accident?

Yes No

Does driver have any physical defect, infirmity, defective vision or hearing?

Yes No

If yes please detail.

Has driver ever been convicted of a motoring offence, or is there any prosecution pending?

Yes No

If yes please detail.

Has driver been involved in any accidents and/or losses in the last 3 years?

Yes No

If yes please detail.

Has driver ever been declined motor insurance?

Yes No

If yes please detail.

Is a full U.K. Driving Licence held?

Yes No

Driving Licence Number.

Date test passed.

For what purpose was vehicle being used at time of accident?Motor

INSURED VEHICLE

Make

Year

Model

Reg No.

Purchase Price

Date of Purchase

Current Value

Can you recover VAT for the vehicle?

Yes No

Is vehicle covered by Hire Purchase/Lease Agreement?

Yes No

If yes please give name, address of company concerned and Agreement Number.

DAMAGE TO INSURED'S VEHICLE

Describe damage

Is vehicle still in use?

Yes No

If No, where is the vehicle now?

Repairers name and address.

Repairers Tel. No.

Cost of repairs

OTHER PARTIES

Name and address of owner/driver.

Insurers.

Policy No.

Vehicle type / make

Reg No.

Damage to vehicle.

DETAILS OF INJURED PERSONS

1) Name and address.

In whose car were they travelling?

Were they a: (a) Driver?

Yes No

(b) Passenger?

Yes No

(c) Pedestrian?

Yes No

Please describe their injuries.

Were they taken to hospital?

Yes No

Were they wearing a seat belt / crash helmet?

Yes No

2) Name and address.

In whose car were they travelling?

Were they a: (a) Driver?

Yes No

(b) Passenger?

Yes No

(c) Pedestrian?

Yes No

Please describe their injuries.

Were they taken to hospital?

Yes No

Were they wearing a seat belt / crash helmet?

Yes No

WITNESSES

1) Name

Address

Was this witness known to you prior to the accident?

Yes No

2) Name

Address

Was this witness known to you prior to the accident?

Yes No

DETAILS OF THE ACCIDENT

Date	<input type="text"/>	Time	<input type="text"/>
Location	<input type="text"/>	Street	<input type="text"/>
Town	<input type="text"/>	County	<input type="text"/>
Condition of road	<input type="text"/>	Width of road	<input type="text"/>
Weather conditions	<input type="text"/>	Visibility	<input type="text"/>

Were the street lights on? Yes No

Applicable speed limit.

INSURED

THIRD PARTY

Estimated speed before accident.	<input type="text"/>	<input type="text"/>
What signals were given?	<input type="text"/>	<input type="text"/>
What vehicle lights were on?	<input type="text"/>	<input type="text"/>

Did the police attend or were they informed? Yes No

If yes please give name and number of attending officer.

Police station address.

Have you received any notice of intended prosecution? Yes No

If yes please give details.

Who do you think was responsible for the accident?

DESCRIBE THE ACCIDENT CIRCUMSTANCES

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

SKETCH PLAN

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PAYMENT OF CLAIM

To avoid postal delays and the risk of theft we will pay any agreed amount due to you in respect of your claim directly into your bank account.

Please complete the following details about your bank account

Bank Name

Bank Account Number

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Sort Code

--	--	--	--	--	--	--

Bank Account Name

If you would however prefer to receive a cheque please tick here

NOTICE

Insurers pass information to the Motor Insurance Anti-Fraud and Theft Register run by the Association of British Insurers (ABI). The aim is to help us to check information provided and also prevent fraudulent claims. Under the Conditions of your Policy, you must tell us about any incident (such as an accident or Theft) which may or may not give rise to a claim. We will pass information relating to this incident to the Register.

DECLARATION

I/WE DECLARE THAT THE PARTICULARS ON THIS FORM ARE CORRECT TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.
I/WE UNDERSTAND THAT YOU MAY ASK FOR INFORMATION FROM OTHER INSURERS TO CHECK THE ANSWERS I/WE HAVE PROVIDED.

Signature of insured

Date

Signature of driver

Date

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