

ACCIDENT REPORT FORM

14 – 16 Ivegate, Yeadon Leeds LS19 7RE
Tel No. 0113 2506614 - Fax No. 0113 3879799



Please make sure that you complete ALL sections of the form correctly

POLICY INFORMATION

Policy Number _____

Name of Policyholder in full _____

Address _____

Tel Number _____

VAT Registered YES / NO If YES, % recoverable _____

VEHICLE DETAILS

Registration number _____ Make _____ Model _____

Has the vehicle been modified from manufacturer's standard? YES / NO If YES, give details _____

Do you own the vehicle? YES / NO If NO, give details _____

Does an HP or leasing company have an interest in the vehicle? YES / NO If YES, give details _____

Who is the registered keeper? _____

DETAILS OF ACCIDENT

Date _____ Time _____ Location _____

Who do you believe was at fault for the accident? _____ Speed of your vehicle prior to impact _____

Weather Conditions _____

Brief Details _____

Did anyone take photographs at accident location YES / NO Number of passengers in your vehicle _____

DRIVER DETAILS

Name _____ Date of Birth _____

Address _____ Date passed driving test for vehicle given _____

_____ Motor claims in last three years (if none, state none) _____

_____ _____

Details of any medical conditions _____ Motoring convictions/pending convictions in last three years

Tel Number _____ (if none, state none) _____

Mobile Number _____ _____

Occupation _____ _____

USE OF THE VEHICLE

Please state the exact purpose for which the vehicle was being used at the time of the incident ('Private' is not sufficient)

DAMAGE TO YOUR VEHICLE

Vehicle Type Car Van HGV Coach

None

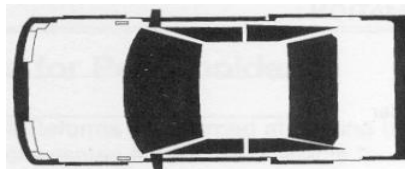
Minor

Serious

Vehicle immobile

Brief description of damage

Indicate areas of damage with XXXXXXXXX



Repairs to your vehicle

A) Insurers approved repairer?

B) To use own garage?

If b, please forward an estimate for the repairs

OTHER VEHICLE INVOLVED

Make / Model / Colour _____

Registration number _____

Driver's name and address _____

Owner's name and address _____

Telephone Number Home _____

Mobile _____

Insurance company name and address _____

Policy number _____

Brief description of damage _____

Number of Passengers in other vehicle _____

WITNESSES

Witness 1

Name and address

Witness 2

Name and address

Did police attend? YES / NO

Was anybody injured (other than driver) YES / NO

PC name/number, police station etc. _____

Details _____

Was anybody cautioned, breathalysed? YES / NO

Did Ambulance attend? YES / NO

Details _____

Signature of policyholder _____ Date _____
(or authorised signatory)

DRIVER'S STATEMENT

I (name).....

of (address).....

.....

Telephone number (own).....(other contact no).....

do make this statement following a road traffic accident on (date) with the third party I now

know as (name).....

of (address).....

THE FACTS

(In your own words, tell us exactly what happened including details of cars involved, weather conditions, visibility etc.)

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SKETCH OF ACCIDENT LOCATION

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true.

Signature:.....

Date:

Print Name.....