

Motor Accident

Report Form



How can we help you? We give claims our greatest possible care and try to deal with them as quickly as possible because we know that this is important to you when you submit a claim.

Please help us to help you by:

- *making sure that the information you give is as clear and complete as possible*
- *remembering to sign and date this form*

Please complete the sections of this form appropriate to your claim.

Continue on a separate sheet of paper if necessary. If you telephone, use this form as a guide.

If you are reporting an incident where someone is, or may be, holding you legally responsible, write to us giving full details of the incident.

Ref No

PARTICULARS OF MOTOR ACCIDENT

1. Insured:

Policy or Insurance Certificate No:

Name:

Address:

Telephone Numbers:

Occupation:

Are You Registered for VAT?

Yes

No

2. Insured's Vehicle:

Make and type:

Reg. letters and numbers:

If goods
vehicle, state

carrying capacity:

unladen weight:

Was vehicle being used:

A. for hire or reward?

Yes No

B. on the insured's order or with his consent?

Yes No

Was a trailer being used ?

Yes No

If 'YES', please give details

Is the vehicle the subject of a Leasing Agreement?

Yes No

If 'YES'
give details:

Name of Leasing Company:

Address:

Account Number:

For what purpose was the vehicle being used at time of accident? (e.g. pleasure, commuting, commercial travelling)

Please Turn Over..

3. Damage to Insured's Vehicle:

If we cover the damage to your vehicle our Approved/recommended Repair Scheme offers advantages including guaranteed repairs.

Details:
of Damage

Repairers Name and Address:
Telephone No:

Estimated cost of repairs: €

What instructions have been given to repairer ?

Where can the vehicle be inspected ?

4. Driver of Insured's Vehicle:

Name:

Address:

Occupation: Date of Birth:

- State whether:
- i) owner of vehicle Yes No
 - ii) owner's paid driver Yes No
 - iii) driving on insured's orders/consent Yes No
 - iv) has motor policy in own name Yes No

Do you suffer from any infirmity or disease ? Yes No
If 'Yes' please give details:

Have you had any previous accidents within the past 5 years ? Yes No
If 'Yes' please give details:

Have you ever been convicted of a motoring offence ? Yes No
If 'Yes' please give details:

Are proceedings pending for a motoring offence ? Yes No
If 'Yes' please give details

If so, give name of Insurers and Policy Number:

has notice of accident been given to them ? Yes No

Licence Number: Vehicle Groups:

Full or Provisional: Date of issue:

If applicable, state heavy goods vehicle or public service vehicle } Licence Number: Date of expiry:

5. Details of Accident :

Date:

Place:

Time: am/pm

Weather conditions:

Estimated speed of Insured's vehicle:

What speed limit is in operation?

Were you governed by yield/stop signs or traffic lights? Yes No

If pedestrian involved, was he/she on a pedestrian crossing? Yes No

Were traffic lights working? Yes No

If not, is there a crossing nearby? Yes No

How did accident occur? (detailed information to be given)

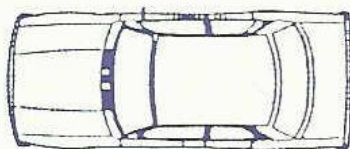
(Continue on separate sheet, if necessary)

Whom do you consider to be at fault and why?

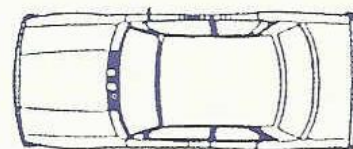
6. Explanatory Sketch:

7. Details of Impact and Area of Damage:

Insured's Vehicle



Other Vehicle



8. Witnesses:

Were particulars of accident taken by a Garda? Yes No

If 'Yes', state Garda's name and station:

Was the Garda a witness to the accident? Yes No

Were any statements of blame made by drivers or witnesses? Yes No

If 'Yes', please give details:

Give names and addresses of all witnesses of accident:

Passengers in Insured's vehicle: 	
Passengers in Third Party vehicle: 	
Independent witnesses: 	
Tel. No. <input type="text"/>	Tel. No. <input type="text"/>

9. Other Parties Involved:

Name & Address of owners of other vehicles involved	Name & Address of driver (if different)	Reg. No. or make of vehicle	Name of Insurer	Policy Number
a) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Name & Address of injured parties	If a passenger, state in which vehicle	Nature of injury	Was seat belt worn ?
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Name & Address of owners of property damaged	Brief details of damage
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Declaration

I/We hereby declare that the statements on this form and the information provided in addition are true and complete, to the best of my/our knowledge and belief.

Signature(s) (Insured) Date

Signature(s) (Driver if different) Date

If you are completing this form for information purposes only rather than submitting a formal claim under your policy please tick this box



The Claims Department, Royal & SunAlliance, 13/17 Dawson Street, Dublin 2.
Telephone: (01) 6771851. Facsimile: (01) 6717625.