Motor Accident Claim Form

Important Note: Please make sure that the information provided is clear and complete as possible. This form should be completed by the policyholder. Please enclose a copy of your licence with this claim form. Please complete in BLOCK letters or on-line save and print.

Claim No:

1. Policyholder Details

Policyholder Name

Policy Number

Contact Telephone Number

2. Person Driving

Person driving at the time of accident (Name)

Date of Birth

Address

Occupation

Relationship to policyholder

Licence No:

Full ☐ Provisional ☐

Date of Issue

Date of Expiration

Does the driver hold a motor insurance policy separately in their own name Yes ☐ No ☐

If 'Yes', please provide name of Insurer

Policy No

For what purpose was the vehicle being used: Business ☐ Social/domestic/pleasure ☐

How long has the driver been: a) driving this vehicle b) any other vehicle

Does the driver have any penalty points Yes ☐ No ☐ Number

At the time of incident, was the driver:

Under any physical or mental infirmity/disability Yes ☐ No ☐

Under the influence of alcohol or drugs Yes ☐ No ☐

Ever refused motor insurance/renewal Yes ☐ No ☐

Ever convicted of any motoring offence or prosecution pending Yes ☐ No ☐

Ever involved in a previous motor accident/claim Yes ☐ No ☐

If you answered 'yes' to any of the above, please provide details below:

3. Insured Vehicle

Vehicle Registration Number

Year of manufacture

Make

Model

Engine size

Number of seats in the vehicle

Has the vehicle passed the NCT/DOE? Yes ☐ No ☐

Date

Cert Number

Are you Registered for VAT Yes ☐ No ☐

Are you paying for the vehicle under a hire purchase or leasing agreement Yes ☐ No ☐

If 'Yes', please provide: Name of hire company

Name of leasing company

Agreement reference number

Was a trailer attached to your vehicle at the time of the incident? Yes ☐ No ☐

To what extent has the vehicle been damaged?

Details of vehicle's current location

If applicable, please provide a copy of the estimate of repairs with this form

4. Circumstances of the Incident

Where did the accident occur?

GPS Co-ordinates: Latitude Longitude (decimal degrees)

Date Time AM /PM

Please confirm how many passengers were travelling in your vehicle at the time of accident

	Passenger 1	Passenger 2	Passenger 3
Name			
Address			

Weather conditions Visibility conditions Road conditions

Was your view obstructed in any way? Yes ☐ No ☐

Speed limit Speed before impact Speed at impact

Name of roads and approximate width

Details of any (1) Traffic Lights

(2) Road Signs/Markings

Please provide details of any warnings given before impact (hand/horn lights/sirens)

Was the incident reported to the Gardaí Yes ☐ Did a member of the Gardaí attend at the scene Yes ☐ No ☐

Provide details : Garda name Badge Number

Station

Please describe in detail how the accident occurred

Do you believe the person driving your vehicle was to blame for the incident Yes ☐ No ☐

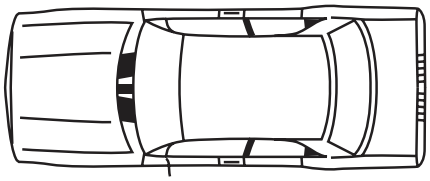
Please outline your reasons

Sketch of Accident

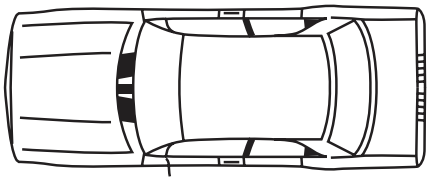
Please draw a sketch of the accident showing the position of the vehicle(s) and person(s) concerned, indicating by arrows the direction each was travelling in.

4. Circumstances of the Incident (continued)

Please indicate using an X any damage caused to your vehicle.



If there was a third party vehicle involved, please indicate by marking with an X any damage to the third party vehicle.



5. Third Party Details (Only to be filled in if a third party vehicle was involved)

How far away was the third party when you first saw their vehicle

Approximate speed of other driver Speed at impact

What signs were given by the third party (hand/horn/lights/siren) How far from impact

Have you made, or are you making, claim(s) upon any other third party? Yes ☐ No ☐

Have any claims been made on you/your driver? Yes ☐ No ☐

If so, by whom?

6. Details of Other Vehicles and/or Property Involved

	1	2	3
Name			
Address			
Phone number / claim reference			
Registration number			
Vehicle make & model			
Insurance company			
Policy number			
Extent of damage			

7. Persons Injured

Please provide details of any injuries arising from the collision

	1	2	3
Name			
Address			
Contact phone number			
Extent of injuries			
State if driver/passenger/ pedestrian/etc.			
In which vehicle if applicable			
Was the person injured wearing a seat belt?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Did the person require medical attention?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Was the person removed to hospital by ambulance?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

8. Witnesses

	1	2	3
Name			
Address			
Phone number			

Please identify if any of the above witnesses was a passenger in your vehicle at the time of incident

Witness 1 ☐ Witness 2 ☐ Witness 3 ☐

All correspondence relating to any claims should be passed directly to IPB Insurance unanswered. No admission of liability should be made about the accident.

9. Declaration

IPB Insurance is registered as a data controller with the Office of the Data Protection Commissioner and is required to comply with the Data Protection Acts 1988 and 2003 and the Code of Practice on Data Protection for the Insurance Sector and further information can be obtained at www.dataprotection.ie. The information you provide to us as part of your claim application will be processed by us to confirm your identity, process and administer your application and to record and cross reference particulars of your claim in insurance industry databases for fraud prevention purposes. This may involve exchanging information with Insurance Link, the anti-fraud claims database run by the Irish Insurance Federation. In certain cases we may also share your information with other insurance providers/ intermediaries, regulatory bodies and private investigators. We may also need to obtain and hold personal sensitive information (e.g. information relating to your health or any relevant convictions) in order to administer this claim. By signing this form, I consent to the processing of the information provided for the purposes of administering this claim and for fraud prevention purposes.

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

Signature _____ Date _____

Please return completed form and enclose a copy of your driving licence with any estimates/valuations/original receipts to :

The Claims Department
IPB Insurance
1 Grand Canal Square, Grand Canal Harbour, Dublin D02 P820, Ireland.
Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: claims@ipb.ie Web: www.ipb.ie