

# TRADEX

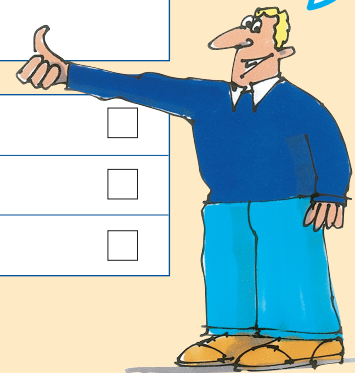
PO Box 31116 London E14 9JQ  
First Response Claims Line 020 7001 9229 • Fax 020 7068 7755 • Email [claims@tradex.com](mailto:claims@tradex.com) • [www.tradex.com](http://www.tradex.com)

## MOTOR ACCIDENT REPORT

(Not for use on theft claims or motor trade)

<b>Policyholder's Name</b>	<input type="text"/>						
<b>Company</b>	<input type="text"/>						
<b>Policy No: (cover note if applicable)</b>	<input type="text"/>						
<b>Broker / Agent: (if applicable)</b>	<input type="text"/>						
<b>Cover Applicable</b>	<table><tr><td><b>Comprehensive</b></td><td><input type="checkbox"/></td></tr><tr><td><b>Third Party Fire &amp; Theft</b></td><td><input type="checkbox"/></td></tr><tr><td><b>Third Party only</b></td><td><input type="checkbox"/></td></tr></table>	<b>Comprehensive</b>	<input type="checkbox"/>	<b>Third Party Fire &amp; Theft</b>	<input type="checkbox"/>	<b>Third Party only</b>	<input type="checkbox"/>
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<b>Third Party only</b>	<input type="checkbox"/>						

Please ensure  
you complete all  
details here



### IMPORTANT

We wish to process your claim as quickly as possible. Therefore please ensure all questions are fully answered and all required documents are enclosed. If in doubt telephone our First Response Claims line.

### PLEASE NOTE

Copies of both the policyholder's and driver's licences must accompany this form. Failure to do so will delay the claim.

Tradex (Underwriting Agencies) plc act as claims settling agents for Tradex Insurance Company Limited and other co-insurers which subscribe to the Tradex Brand Products. Tradex (Underwriting Agencies) plc is the management company for Tradex Insurance Company Limited who is regulated by the FSA and a member of GISC.

**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 YES  NO  VAT STATUS Full / Partial recovery VAT Number

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

Full Names  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  Provisional  HGV  PSV  Other (state nationality)

Was the vehicle being used with Policyholder's consent YES  NO  If not the Policyholder driving, does the driver have his own insurance YES  NO

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 below. Use a separate sheet if necessary.

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)	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

Date of purchase  Purchase price £

Has the vehicle been modified in any way YES  NO  If YES, give details

In the event of a 'Total Loss', please complete the following:

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

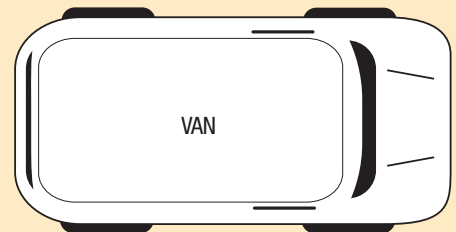
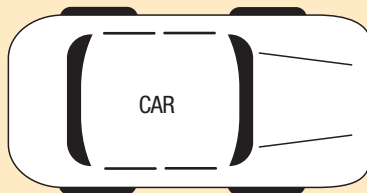
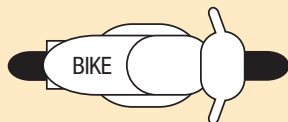
**Note: In the event of a total loss, claims will be paid to the Finance / Leasing Company.**

### 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

Repairers Name

Repairers Telephone Number  Repairers Fax Number

Repairers Address

Post Code

Have you attached an estimate to this form YES  NO

Are you satisfied that the repairers 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

Exact location (Road, Town / County)

Speed limit

Width of road

Your Vehicle

Third Party Vehicle (if applicable)

Speed of vehicle prior to accident

Distance from nearside kerb

What lights were displayed

What signals were given

What warnings were given

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

Describe fully how the accident occurred

Sketch details overleaf

continued overleaf...

## 6 CONTINUED

**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



## 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

## 7 CONTINUED

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 below

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 via electronic transfer direct to your bank account. 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 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 Photograph(s) of vehicle if available