

# Motor Accident Claims Form

To complete this form, fill in the designated highlighted fields. Please ensure you save the form to your computer. You can then either print it and return it to your broker by post/fax or email the electronic version. Alternatively send the form directly to: Travelers Insurance Designated Activity Company. Third Floor, Block 8, Harcourt Centre, Charlotte Way, Dublin 2, Ireland' Tel: 01 609 5600 Fax: 01 609 5640 Email: [ieclaims@travelers.com](mailto:ieclaims@travelers.com)

DATA PROTECTION: We share and exchange all claims information with the Insurance Link database, run by the Irish Insurance Federation. The aim is to help us check information and prevent fraudulent claims. When you tell us about an incident, we will pass information about it to the register. For further information - [click here](#) to email the Compliance Manager at Travelers Insurance.

Broker

Policy Number

The issue of this form is not an admission of liability on the part of the company

**INSURED** (Please answer every question fully; failure to do so will result in delay. Please write in block capitals.)

Title

First Name(s)

Surname

Address

Date of Birth

Telephone Number (Private)

Telephone Number (Business)

Mobile Number

Are you registered for VAT?

Yes No

All occupations (full and part time)

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

Title First Name(s) Surname

Address

Date of Birth How long resident in Ireland? Date Irish driving test passed

Type of licence Relationship of driver if other than Insured Driving licence number Licence expiry date

If driver other than Insured, does he/she have a policy of their own? Yes No  
If 'Yes', name of company and policy no.

Have you or the driver ever been convicted of any offence or incurred a fine? Yes No

Have you or the driver ever been involved in any other incident in connection with a motor vehicle? Yes No

Have you or the driver ever been refused insurance or had any insurance cancelled or been refused renewal? Yes No

Have you or the driver ever suffered from or are currently suffering from any physical or mental disability? Yes No

If the answer to any of the above question is 'Yes' ( please give full details below

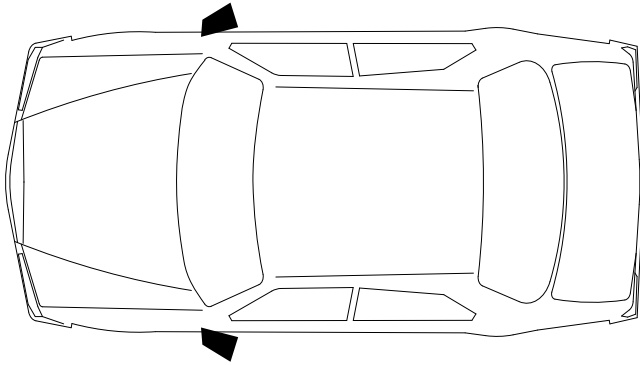
Date	Driver	Details	Conviction Type/Code	Fine/Sentence
<b>Physical/Mental Disability</b>				



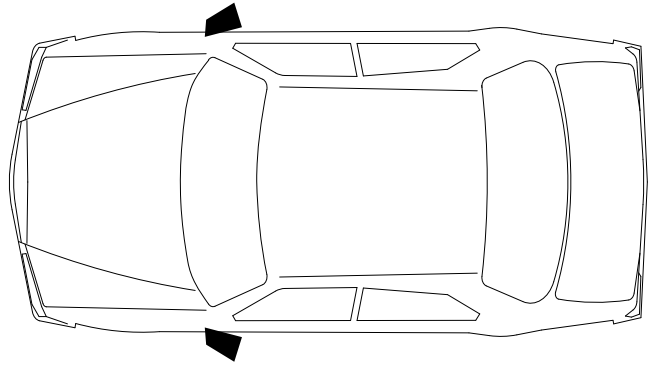
## DAMAGE TO VEHICLE

Indicate area of damage to the vehicles

Insured's vehicle



Other vehicle



Describe the nature of the damage to the vehicles:

Estimated repair costs to own vehicle?

Estimated repair costs to other vehicle (if known)

Is your vehicle at the repairer now?

Yes No

Repairer's name

Telephone No:

Repairer's address

## DETAILS OF INSURED VEHICLE OR VEHICLE BEING DRIVEN AT THE TIME

Date

Time (am/pm)

Weather and road conditions

Exact location of accident (road, town/country)

	Insured 's vehicle	Third party vehiclew
Speed of vehicle prior to accident?		
Distance from nearside kerb?		
What lights were displayed?		
What signals were given?		
What warnings were given?		

Describe fully how the accident occurred

Who in your opinion was to blame for the accident and why?

Sketch plan – please draw a sketch of the road(s) showing the position of the vehicles at the point of impact. Indicate directions of arrows. Please show road signs/markings and directions of the nearest towns. Show your vehicle as

**DETAILS OF OTHER VEHICLES OR PERSONS INVOLVED** *(use a separate sheet if necessary)*

Make of Vehicle

Registration No.

Name of owner

Address of owner

Details of Insurers

Damage to vehicle

**Witnesses**

Name and address of own passengers

Name and address of any other witnesses

Was the incident reported to the Gardaí?  
If 'Yes', give details of garda and station

Yes No

Are any prosecutions pending/resulting?  
If 'Yes', give details

Yes No

Were alcohol or drugs in any way contributory factors?

Yes No

Was any person injured?  
If 'Yes', give full details below

Yes No

Name

Address

Nature of injuries

Detained in hospital?

Yes No

Yes No

Yes No

If 'Yes', give name of hospital

Any claim against you; including any communication from the gardaí must be passed to us immediately unacknowledged

## USE OF VEHICLE AT TIME OF ACCIDENT

Please state EXACT USE of vehicle (if vehicle not being driven, the use prior to parking)  
(Please note Social/Pleasure etc is not adequate: detailed description is required)

Number of passengers carried

Were the passengers wearing seatbelts?

If a commercial vehicle, state weight of load

If a commercial vehicle, state nature of goods being carried

## DECLARATION

I/We declare that the foregoing particulars are true to the best of my/our knowledge and belief. I/We authorise the Company to make such admissions on my/our behalf as it deems appropriate and I/we agree to render to the Company all assistance in the investigation of the claim. I/We further agree to provide such assistance as may be necessary in pursuing recovery of any outlay.

Signature of the Proposer

I am an authorised signatory and by submitting this proposal in electronic form, acknowledge such as if having signed it

Date

Signature of driver

Date

Please return your completed claims form to your broker or to:

**Third Floor, Block 8, Harcourt Centre, Charlotte Way, Dublin 2, Ireland'**

**Tel: +353 (0) 1 609 5600 Fax: +353 (0) 1 609 5640 Email: ieclaims@travelers.com**

## BROKER ONLY PLEASE ENSURE

All questions have been answered

Licence copies attached

Vehicle Licensing Cert

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Travelers operates through several underwriting entities through the UK and across Europe. Please consult your policy documentation or visit the websites below for full information.

[travelers.co.uk](http://travelers.co.uk)

[travelers.ie](http://travelers.ie)