

1. INSURED

Name _____

Address _____

Occupation _____

Home Tel. No: _____

Business Tel. No: _____

Policy No

Broker/Agent

Are you registered for VAT? YES NO

2. DRIVER

Name _____

Occupation _____

Address _____

Home Tel. No: _____ Business Tel. No: _____

Age _____ Date of Birth D ____/M____/Y ____

Driving Licence No: _____

Date of Expiry D ____/M____/Y ____

Type of Licence Held: FULL PROVISIONAL

If "Full" please state place and date when test passed: _____

If "Provisional" please state length of driving experience: ____ years

Had the driver ever been convicted of any Driving Offence YES NO

If "yes" give details (dates, offences and penalties) _____

Had the driver been concerned in any previous accident in the last 5 years YES NO

If "yes" give details _____

If driver other than owner, does he/she own a vehicle? YES NO

If "Yes" state type of vehicle: _____

Insurers of vehicle _____

3. VEHICLE

Vehicle Reg. No.	H.P. or C.C.	Make & Model
Year of Make	Present Mileage	
Total seating capacity including driver's seat	How many passengers were being vehicleried?	Was trailer attached? <input type="checkbox"/> Yes <input type="checkbox"/> No

For what precise purpose was the vehicle being used?

Estimated value of vehicle at time of accident _____

Is the vehicle:

(a) Owned by the Insured? Yes No
 If "No" give name & address of registered owner?

(b) Registered in the Insured's name? Yes No
 If "No" give name of registered person

(c) Hired or Leased? Yes No
 If "Yes" give name of Leasing or Hire Company

Has the vehicle been altered or modified in any way? Yes No

If "Yes" please give details _____

Damage to the Insured Vehicle

Did your vehicle sustain any damage? Yes No

If "Yes" please give details of visible damage _____

Please state name and address of repairers where vehicle may be inspected _____

_____ Phone No. _____

Is the vehicle at the repairer now? Yes No

If "No" when will it be taken there? _____

4. ACCIDENT

Time ____ a.m. p.m. Date D ____/M____/Y ____

Exact place _____

What was the width of the Road? What were the weather conditions? Were street lights on? Yes No

4. ACCIDENT contd.

	Insured Vehicle	Third Party Vehicle	If "Yes" give details _____
Estimated speed	_____	_____	_____
Position on Road	_____	_____	_____
Was horn sounded?	_____	_____	_____
What lights were used?	_____	_____	_____
Was the accident reported to Na Gardai/Police	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Was an oral warning given at the scene? <input type="checkbox"/> YES <input type="checkbox"/> NO
Did they take statements?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If "Yes" give details _____
Was either driver breathalysed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Please state: Name and Number of Garda/Officer (if known) _____
			Address of Garda/Police Station _____

5. OTHER PARTIES (OWNERS, DRIVERS ETC.)

Name and address of Driver or Owner	Vehicle Registration	Extent of Damage	Insurance Company and Policy No. (if known)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. PASSENGERS IN INSURED'S VEHICLE (if more than three, please supply details separately)

Full name	1. _____	2. _____	3. _____
Address	_____	_____	_____
	_____	_____	_____
State where seated	<input type="checkbox"/> Front seat <input type="checkbox"/> Rear Seat	<input type="checkbox"/> Front seat <input type="checkbox"/> Rear Seat	<input type="checkbox"/> Front seat <input type="checkbox"/> Rear Seat
Was seat belt worn?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

7. INJURED PERSONS: (if more than three, please supply details separately)

Full name	1. _____	2. _____	3. _____
Address	_____	_____	_____
	_____	_____	_____
	_____ age _____	_____ age _____	_____ age _____
Was this person: removed to hospital?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
detrained in hospital?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

8. WITNESSES (if more than three, please supply details separately)

Full name	1. _____	2. _____	3. _____
Address & Tel No.	_____	_____	_____
	_____	_____	_____
(state if independent)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

9. FULL DESCRIPTION OF ACCIDENT (if insufficient space please supply details separately)

10. SKETCH PLAN OF ACCIDENT:

Please make a rough plan of the road, showing positions of vehicles and persons concerned. An arrow should indicate the direction in which they were moving

Who or what, in your opinion, was the cause of the accident?

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I/We hereby certify the foregoing particulars to be true and complete in every respect. I/we understand that the information given on this form may be submitted to solicitors for use in connection with any litigation arising out of this accident.

Signature of Insured: _____ Date _____

(If a company or firm, give status of signatory):