

# Motor Claim Form



**Important note: Please make sure that the information you give is as clear and complete as possible. You must enclose a copy of your licence with this claim form. Please complete in BLOCK CAPITALS.**

Type of claim (please tick)      Accident       In the event of an **accident** please complete all sections except section 9.  
Theft/Attempted Theft       In the event of a **theft** please complete sections 1,2,3,9,10b and 11 only.

Claim No:

## 1. Policyholder Details

Policyholder Name:       Policy No:

Is the policyholder registered for VAT?      Yes       No

## 2. Person Driving (in event of theft/attempted theft, give details of person last in charge of vehicle)

Person driving at time of accident:       Date of Birth:  /  /

Licence No:       Full       Provisional

Date of Issue:  /  /       Date of Expiration:  /  /

Was the driver separately insured under any other motor policy?      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

### 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

Convicted of any motoring offence or prosecution pending?      Yes       No

Involved in a previous motor accident or claim?      Yes       No

If you have answered yes to any of the questions above, please give full details:

  
  

## 3. Vehicle Details

Make:       Model:

Engine size (cc)       Registration No:

Has the vehicle passed the NCT/DOE      Yes       No

Date:  /  /       Cert. NO:

To what extent has it been damaged?

Where may the vehicle be inspected?

**Please submit a copy of the estimate with this form.**

#### 4. Accident Details

Date:  /  /  Time:  Place:

Was accident reported to the Gardai? Yes  No

Name of Garda and station:

Weather conditions:  Visibility conditions:  Road conditions:

Name of roads and approximate width:

Were the roads controlled by traffic lights/sign/warden?

Details of any (1) Road Signs:

(2) Road Markings:

Was your view obstructed in any way?

Speed limit:  Speed before impact:  Speed at impact:

What signals were given: (hand/horn/lights)  How far from impact:

#### 5. Third Party Details (Only to be filled in if a Third Party Vehicle was involved)

How far away was the third party when first seen by you:

Approximate speed of other driver before impact:  Speed at impact:

What signals were given (hand/horn/lights) by the third party?  And how far from impact:

Who do you feel was responsible for the accident and why?

<hr/> <hr/> <hr/>
-------------------

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. Other vehicle(s) or property involved

	1	2	3
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Reg No:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vehicle make/model:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Insurance Company:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Policy No:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nature/extent of damage:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Third Party Claim No:	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 7. Person(s) injured

	1	2	3
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Age:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Extent of Injury:	<input type="text"/>	<input type="text"/>	<input type="text"/>
State if driver/passenger:	<input type="text"/>	<input type="text"/>	<input type="text"/>
In which vehicle?	<input type="text"/>	<input type="text"/>	<input type="text"/>
Was the person(s) injured wearing a seat belt:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

### 8. Witness(es)

	1	2	3
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<input type="text"/>	<input type="text"/>
State if passenger/ pedestrian/etc	<input type="text"/>	<input type="text"/>	<input type="text"/>
If passenger, state in which vehicle?	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 9. Theft of Vehicle and Unrecovered Vehicle

Date:  /  /  Time:  Place:

Was accident reported to the Gardaí? Yes  No

Name of Garda and station:

Approximate mileage at time of theft:  Length of time vehicle was left unattended:

What security measures were in force? (CCTV/Security Guards):

Was the vehicle locked and all windows secure at the time?

Were there any witnesses to the incident? Yes  No  Name:

Address:

Please list any personal effects stolen and not recovered from the vehicle:

## 10. Sketch and Detail Accident/Theft

**10A. Sketch** 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.

**10B. Please explain the accident/ theft in detail?**

---

---

---

---

---

---

---

---

---

---

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

## 11. Declaration

IPB is classified as a Data Controller under Irish Data Protection Legislation. The information you provide to us as part of your claim application will be processed by us to confirm your identity, process 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 and private investigators.

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  
Irish Public Bodies Mutual Insurances Ltd.  
12-14 Lower Mount Street, Dublin 2.

Tel: +353 1 639 5500 Fax: +353 1 639 5540 Email: [motor.claims@ipb.ie](mailto:motor.claims@ipb.ie) Web: [www.ipb.ie](http://www.ipb.ie)

Reg. No. 7532 Republic of Ireland.

Irish Public Bodies Mutual Insurances Ltd. is regulated by the Central Bank of Ireland.



QUALITY  
ISO 9001:2008  
NSAI Certified