



# ARB Insurance Incident Report Form

Please answer all questions fully, where applicable.

## 1. INSURED DETAILS

Full Name	<input type="text"/>	Policy Number	<input type="text"/>
Address	<input type="text"/>	Home Telephone	<input type="text"/>
		Work Telephone	<input type="text"/>
		Driving Licence: Full / Prov	<input type="text"/>
		Categories	<input type="text"/>
Address: (Business)	<input type="text"/>	Licence Number	<input type="text"/>
		Expiry Date	<input type="text"/>
Date of Birth	<input type="text"/>		
All Occupations (Full & Part Time)	<input type="text"/>		
Are you registered for VAT	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

## 2. DETAILS OF ACCIDENT

Date	<input type="text"/>	Time	<input type="text"/>	am/pm	Weather Conditions	<input type="text"/>
Road Conditions	<input type="text"/>		Width of Road	<input type="text"/>		
Accident Location (Road, Town/County)	<input type="text"/>					

	INSURED VEHICLE	THIRD PARTY VEHICLE
Speed of Vehicle prior to Accident?	<input type="text"/>	<input type="text"/>
Distance from nearside Kerb?	<input type="text"/>	<input type="text"/>
What lights were Displayed?	<input type="text"/>	<input type="text"/>
What Signals were given?	<input type="text"/>	<input type="text"/>
What warnings were given?	<input type="text"/>	<input type="text"/>

Were Alcohol/Drugs in any way a contributing factor to the accident	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If 'YES' give details.				

Was the driver's view obstructed in any way?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If 'YES' give details.				



**3. PERSON DRIVING (In the event of FIRE & THEFT give details of person last in charge)**

Full Name

Policy Number

Address

Home Telephone

Work Telephone

Driving Licence: Full / Prov

Categories

Address:  
(Business)

Licence Number

Expiry Date

Date of Birth

All Occupations (Full &amp; Part time)

Relationship of driver if other than insured ☐ Spouse ☐ Child ☐ Parent ☐ Friend ☐ Employee ☐ OthersDid the driver have the policyholder's permission to drive the vehicle ☐ Yes ☐ No

State the purpose for which the vehicle was being used. (Terms such as social, domestic &amp; pleasure are not sufficient)

Was the driver separately insured under any Motor Policy at the time of this accident ☐ Yes ☐ No

If 'YES', give name and address of Insurance Company along with the policy number.

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 accident?

Yes

No

Is the driver the main user of the vehicle?

Yes

No

Have you or the driver ever been refused insurance, had insured cancelled,  
Been refused renewal or had special terms imposed?

Yes

No

Does the driver suffer from diabetes, epilepsy, heart condition or any other medical condition?

Yes

No

If yes, please give details

**4. DETAILS OF INSURED VEHICLE OR VEHICLE BEING DRIVEN AT THE TIME**

Registration Number

Year of Make

Make &amp; Model

CC

Est. Value

Is the vehicle owned by the insured?

☐ Yes☐ No

Is the vehicle registered in the insured's name?

☐ Yes☐ No

If 'NO' please give details of the owner / registered keeper:

Does any financial institutions or hire purchase company have an interest in the vehicle?

Please describe the damage to your vehicle:

Please advise where the vehicle may be inspected?

Tel.

**5. DETAILS OF OTHER VEHICLE(S) OR PERSONS INVOLVED**

Name of Owner			
Address			
Name of driver			
Vehicle Reg No.			
Make & Model			
Extent of Damage			
Insurance Co			
Policy No.			

**Persons Injured**

Name			
Address			
Age			
Occupation			
Injury Details			

Were seatbelts worn?    Yes ☐    No ☐                      Yes ☐    No ☐                      Yes ☐    No ☐

Hospitalised?                      Yes ☐    No ☐                      Yes ☐    No ☐                      Yes ☐    No ☐

Name of Hospital			
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**6. FIRE / THEFT ~ complete A or B as applicable & C****A. IF FIRE**

State date:		Time:		am/pm
State Cause of Fire:				
Address of Fire Brigade attended:				
Where can the vehicle be inspected?				
Extent of Damage:				

B. IF THEFT

State date vehicle was left		Time	am/pm
State date that vehicle was discovered missing		Time	am/pm
State date vehicle was recovered (if applicable)			
And by whom?			
Where can the vehicle be inspected?			
Was the incident reported to the Gardai?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
If No please advise why?			
If Yes please advise reporting Garda's name and address of station:			
What precautions were taken to prevent the theft			
Where exactly were the keys at the time of the			
Your estimate of current value	€		

B. DESCRIPTION OF INCIDENT

Describe fully ~ How the Fire / Theft occurred

State ~ Names and addressed of any  
Persons having knowledge  
Of the loss circumstances.

Have the Gardai apprehended any  
Persons in connection with this  
Incident?

☐ Yes

☐ No

If 'YES' please give full details

**IF THE VEHICLE MAINS MISSING AFTER 28 DAYS, PLEASE FORWARD**

- |  |  |
|--|--|
| 1. Vehicle Registration Document or Tax Book                                     | 5. Full Service History (If available) |
| 2. Certificate of Insurance and items missing                                    | 6. Purchase receipts for the vehicle   |
| 3. Vehicle Keys (including spare sets)<br>Value and condition of Vehicle         | 7. Any other documents to establish    |
| 4. Vehicle alarm control and / or immobiliser<br>Keys (including all spare sets) |  |

**THIS FORM MUST BE COMPLETED BY THE GARDA SIOCHANNA AND RETURNED TO US WITHIN FORTY EIGHT (48) HOURS NOTIFICATION TO 'AN GARDA SIOCHANNA'**

I / We wish to confirm the Theft / Loss of the €  from (Address / Scene)   
Undernoted property valued at approximately

On (Date)

Reg. No	CC	Fuel Type	Make	Year	Make & Model	Mileage at Date of Loss
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**CERTIFICATION TP BE COMPLETED BY AN GARDA SIOCHANNA  
TO  
ARB UNDERWRITING LTD.**

This is to certify that (full name)

Of (address)

Reported to this station on this date the Theft / Loss of:

We have noted for our records the interest of ARB Underwriting Ltd, in this property.

Signed

Dated :

Please stamp  
this form ↓

Garda Station Address

**STAMP**

**DECLARATION**

**I/WE DECLARE** that to the best of my/our knowledge and belief all the foregoing particulars are true and correct in all respects, and request you to deal on my/our behalf with any claims which may arise out of the accident in accordance with the terms and conditions in the policy. I/We authorise you and/or your Solicitor on my/our behalf to make such admissions and settlements, and give such consents as you may consider necessary for the disposal of such

Signature of Policyholder

Date

Signature of driver

Date

**BROKER USE ONLY**

**ALL QUESTIONS HAVE BEEN ANSWERED FULLY**

☐

**COPIES OF DRIVERS LICENCE ATTACHED**

☐

7. ADDITIONAL INFORMATION