TPCN	
Document:	Form #378
Issue:	#5
Related to:	All Contracts

Claim Reference Number:

The information provided in this form will be handled in accordance with the Data Protection legislation. In addition to the person who issued this form, the information may be shared with the Scottish Ministers, their contractors, insurers and professional advisors. For more information about Data Protection, visit www.ico.gov.uk

Part 1 – About yourself

1. Name
   (Mr/Miss/Ms/Mrs).....
2. Address .....
   .....
   .....
   .....
   .....
3. Email Address .....
4. Daytime Telephone Number (including STD code) .....

Part 2 – About your vehicle (if damaged)

1. Class (e.g. car, lorry, motorcycle, moped, bicycle) .....
2. Make model and year of manufacture.....
3. Registration number (if motor vehicle) .....
4. Name and address of insurers
   .....
   .....
   .....
   .....
5. Policyholder's name (if not claimant) .....
6. Have you claimed from your insurers in respect of this incident? Yes____No____
7. If YES, policy number .....

Part 3 – About your accident

1. Time and date of incident ……

2. Location of incident (e.g. A82, 2 miles south of Fort William). If you have any photographs relating to the incident, please enclose them. (See also 8 below regarding a sketch)

   ……

3. In which direction were you travelling? ……..……..

4. Please tick the boxes which best describe conditions at the time of the incident

   The road/footpath was wet….. dry….. icy…. other……
   The weather was clear…. foggy….. raining…. snowing…. other……

5. At what speed were you travelling? ……..……

   (pedestrians should indicate whether they were walking/running etc)
   ……

6. What warning signs did you see, if any, immediately before the incident?

   ……

   ……

7. Brief description of the events leading up to, during and immediately after the incident……

   ……

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   ……

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   ……

8. Please provide in the space below a sketch of the location of the incident, showing landmarks such as bridges, road signs, motorway marker posts, etc.

Part 4 – Particulars of damage and/or loss

1. Details of damage to vehicle ……..…….....

   ……..…….....

   ……..…….....

2. Details of damage to property or other material loss ……..

   ……..…….....

   ……..…….....

   ……..…….....

3. Did you suffer any physical injury as a result of this incident? Yes_____No_____If YES, please complete the CRU Section of this form. Please also describe your injuries and indicate who treated you and when ……

   ……..…….....

   ……..…….....

   ……..…….....

   ……..…….....

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   ……..…….....

4. Amount of claim (please enclose written receipts) £……...

5. In order to prevent and detect fraud, additional investigations may be carried out as appropriate.

   If you are making a claim in respect of personal injuries, please complete the mandates attached. These documents authorise the hospitals, your general practitioner or other health or medical institutions that treated you to provide us with a medical report, disclose your medical history and your medical records only as regards the injuries you sustained arising from the circumstances of this claim. Complete the mandate in BLOCK CAPITALS and do not detach it. We require you to complete more than one mandate if you received treatment at more than one health or medical institution in respect of this incident, as these institutions may not accept photocopies of signed mandates.

   Your attention is also drawn to the need to complete the enclose CRU Section form

Mandate

(Enter below the full name and address of the hospital, general practitioner or other health or medical institution where you received treatment and to which this mandate relates)

To:

……

……

……

……

……

…… (enter your full name) of

…… (enter your address) born on

…… (enter your date of birth)

hereby authorise you to provide to the Operating Company and/or to the Scottish Ministers a full medical report, full statement of my medical history and all books, medical records, charts, X-rays, notes and other documents held by you relating to me showing or tending to show the nature, extent and cause of all injuries sustained by me on …… [enter date of accident], the treatment received by me since this date and my certificate of discharge, if any.

Signature …… Date ……..

Mandate

(Enter below the full name and address of the hospital, general practitioner or other health or medical institution where you received treatment and to which this mandate relates)

To:

……

……

……

……

……

…… (enter your full name) of

…… (enter your address) born on

…… (enter your date of birth)

hereby authorise you to provide to the Operating Company and/or to the Scottish Ministers a full medical report, full statement of my medical history and all books, medical records, charts, X-rays, notes and other documents held by you relating to me showing or tending to show the nature, extent and cause of all injuries sustained by me on …… [enter date of accident], the treatment received by me since this date and my certificate of discharge, if any.

Signature …… Date ……..

Part 5 – About witnesses to the incident

1. Please provide names and addresses of other occupants of your vehicle (if any) Name

…… Name …… Address

…… Address ……

…… ……..

…… …….. Name

…… Name …… Address

…… Address ……

…… ……..

…… ……..

2. Were the police involved? Yes_____No_____

If YES, please give details and police reference (if known)

……

……

3. Please provide names and addresses of other witnesses to the incident and say why they are witnesses (e.g. passer-by, other motorist)

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Part 6 – Other information and signature

1. Please use this space to supply any other information that you think is relevant to the claim or to make any other comments

……..…….

……..…….

……..…….

……..…….

……..…….

……..…….

2. Please sign and date the form

Signature ……..…….. Date ……

NAME IN BLOCK CAPITALS ……

CRU SECTION - *ONLY TO BE COMPLETED IF YOU SUFFERED PHYSICAL INJURY*
THE SOCIAL SECURITY (RECOVERY OF BENEFITS) REGULATIONS1997

Please provide the following which must by law be passed to the Department for Work and Pensions by the party being claimed against. (Do not detach this form)

Full Name …….. National Insurance No ……..…….. Date of Birth …….. ……. Details of your solicitor or representative (if appropriate)

Name ……...……..

Address
……

…….. Post Code

……..……... Reference

……. Details of your employment at the time of the accident (if appropriate)

Name of Employer ……..……

……

…….. Post Code

……..……... Department

……..…….. Clock or Works Number ……..……. I declare that the above information is correct to the best of my knowledge.

Signed …… Date ……..……

* Claimant/claimant's representative

Block Capitals ……...……

* Delete as appropriate