Our Ref: **{** MERGEFIELD MATTER_FEE_EARNER_ID **}/{** MERGEFIELD client_no **}/{** MERGEFIELD matter_no **}**

Date: **{** SET LETTER**{** DATE \@ "d MMMM yyyy" **} }{**ref LETTER \@ "d MMMM yyyy" \ * MERGEFORMAT **}**

ACCIDENT QUESTIONNAIRE

You have losses and these will need to be claimed from the negligent party. When completing this form we only need answers for those sections which apply to you, but please complete the form fully and carefully since it is designed to give the information necessary to deal with your claim and information left off will lead to delays in settlement.

ACCIDENT QUESTIONNAIRE	**ANSWERS**
Personal Details:-	
1. NAME	
2. ADDRESS	
3. TELEPHONE	
4. DATE OF BIRTH	
5. YOUR NATIONAL INSURANCE NUMBER	
6. MARITAL STATUS	
7. NAME OF NEXT OF KIN IF UNDER 18	
Accident Details:-	
8. DATE AND TIME OF ACCIDENT	
9. PLACE OF ACCIDENT	
10. DESCRIPTION OF HOW ACCIDENT OCCURRED (AND SKETCH PLAN IF R.T.A SHOWING POSITION OF VEHICLES, ROAD SIGNS AND LIGHTS, WITNESSES ETC. (PLEASE USE OTHER SIDE OF PAPER IF MORE SPACE IS NEEDED)	
11. ROAD CONDITIONS	
12. VISIBILITY	
13. WERE YOU A PASSENGER OR DRIVER	
14. PLEASE PROVIDE THE NAME, ADDRESSES AND TELEPHONE NUMBERS OF ALL PEOPLE IN	

THE SAME VEHICLE AS YOU INJURIES RECEIVED	
15. POLICE STATION ACCIDENT REPORTED TO	
16. HAVE YOU RECEIVED A NOTICE OF INTENDED PROSECUTION	
17. HAS YOUR OPPENENT BEEN SO NOTIFIED	
18. WERE SEAT BELTS FITTED AND WORN BY YOU	
19. HAVE YOU HAD ANY PREVIOUS CONVICTIONS ENDORSEMENTS	
Witness Details:- 20. NAMES, ADDRESS AND TELEPHONE NUMBER OF WITNESSES	
Vehicle and Third Party Details:- 21. NAME, ADDRESS AND TELEPHONE NUMBER OF DRIVER RESPONSIBLE FOR YOUR ACCIDENT.	
22. NAME, ADDRESS AND TELEPHONE NUMBER OF OWNER OF VEHICLE RESPONSIBLE FOR YOUR ACCIDENT	
23. MAKE AND MODEL OR AND VEHICLE REGISTRATION NUMBER OF VEHICLE RESONSIBLE FOR ACCIDENT	
24. THIRD PARTY DRIVERS INSURANCE COMPANY AND POLICY NUMBER	
Your Own Vehicle Details:- 25. MAKE AND MODEL OF AND VEHICLE REGISTRATION NUMBER, INSURERS OF YOUR VEHICLE	
26. TYPE AND EXTENT OF YOUR INSURANCE COVER	
27. PLEASE PROVIDE YOUR INSURANCE	

COMPANY'S NAME, ADDRESS, TELEPHONE NUMBER AND REFERENCE	
Your Employment Details:- 28. EMPLOYER'S NAME	
29. EMPLOYER'S ADDRESS	
30. OCCUPATION	
31. GROSS EARNINGS pw	
32. NET EARNINGS pw	
Details of Injuries Suffered:- 33. **INJURY QUESTIONNAIRE**	
IF ANY OF YOUR PASSENGERS WERE INJURED THEY SHOULD BE ABLE TO MAKE A CLAIM AND THEY SHOULD CONTACT US IMMEDIATELY. PLEASE TICK BELOW (where appropriate)	
WHIPLASH	TREMBLING
BROKEN LIMBS	LOSS OF SLEEP
CUTS	ANXIETY
BRUISING	APPREHENSION IN A CAR
SHOCK	SHAKING UP
OTHER (set out below)	
34. PLEASE STATE MORE FULLY THE EFFECTS OF THE ACCIDENT UPON YOU	

35. HAVE THE EFFECTS NOW SUBSIDED AND IF SO HOW LONG DID THEY LAST?	
36. PLEASE COMPLETE THE MEDICAL AUTHORITY AT THE END OF THIS QUESTIONNAIRE	

Your Wage Loss:-		
37. DID YOU RECEIVE STATUTORY SICK PAY		YES / NO
38. DID YOU RECEIVE WELFARE BENEFITS		YES / NO
39. **APPROXIMATE WAGE LOSS**		
	HOW LONG OFF WORK?	
	ARE YOU BACK AT WORK?	YES / NO
	DID YOU LOSE ANY EARNINGS AS A RESULT OF THE ACCIDENT	YES / NO
	IF SO, HOW MUCH NET	£

40. IF YOU HAVE RETURNED TO WORK, OR WHEN YOU DO RETURN TO WORK PLEASE TELL US IF YOU HAVE NOT RETURNED TO YOUR NORMAL DUTIES AND OVERTIME	
41. IF NOT YET BACK AT WORK, PLEASE ADVISE US OF THE DATE YOU RETURN	

Your Other Losses and Expenses:-

PLEASE GIVE FULL DETAILS OF ALL LOSSES.

I …… of ……..

hereby confirm that the information given in the Accident Questionnaire is true.

Signed ----------

Dated ----------