

"WITHOUT PREJUDICE"

MOTOR VEHICLE CLAIM FORM

This form is sent whenever an accident or loss is intimated. It must be completed and returned within **2 days** of receipt.
All questions **must** be answered fully. Dashes are not sufficient. Please use **BLOCK LETTERS**
(Where questions require a "Yes" or "No" answer, tick that which is applicable)

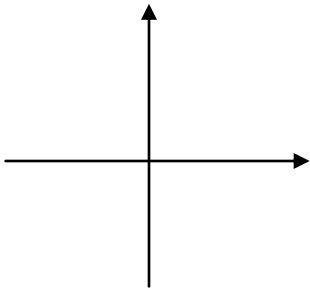
Issued by
From (office)
Date issued

Policy Number

| | | | |
|---|---|---------------------------------------|---|
| 1. THE PREMIUM | Paid to : | | Date: |
| 2. THE INSURED | Full Names (Mr./Mrs./Miss) | | Surname/Family Name |
| 2.1 Full residential address | | | E-mail |
| 2.2 P O Box/Telephone No.s | P O Box Number | Business Telephone | Home Telephone |
| 2.3 Occupation/Date of birth | Occupation | | Date of Birth |
| 3 THE VEHICLE | Date purchased by Insured | From whom | Estimated value at the time of loss \$ |
| 3.1 Manufacture details | Make Year | Carrying Capacity | Type of Body Horse Power/c.c. |
| 3.2 Registration Book Specifications | Registration Number | Engine Number | Chassis Number |
| 3.3 Hire Purchase/Lease Details | Name of Hire Purchase/Lease Company | | Amount owing \$ |
| 3.4 Is vehicle owned by the Insured? | Yes <input type="checkbox"/> | If "No", please advise by whom? | |
| | No <input type="checkbox"/> | | |
| 3.5 Is vehicle modified to increase performance above specifications? | Yes <input type="checkbox"/> | If "Yes", please provide full details | |
| | No <input type="checkbox"/> | | |
| 3.6 Description & name of owner of any goods carried in the vehicle. | | | |
| 3.7 Description & number of trailers attached to the vehicle. | | | |
| 3.8 Give details of damage to the insured vehicle. | | | |
| 3.9 Estimated cost of repairs & where it can be inspected? | | | |
| 3.10 For motor cycles only | Was side-car attached? | Pillion passenger carried? | Was driver a learner? |
| 4. THE DRIVER | N.B. These questions must be answered whether the insured was driving the vehicle or not | | |
| 4.1 Full names | Mr./Mrs./Miss. First Names | Surname/Family Name | |
| 4.2 Full residential address | | | |
| 4.3 P O Box/Telephone Numbers | P O Box Number | Business Telephone | Home Telephone |
| 4.4 Occupation/Date of birth | Occupation | | Date of Birth |
| DRIVING LICENCE | Date first issued | Place of issue | Licence number |
| 4.5 (must be produced) | | | |
| 4.6 Details of licence | Authorised classes | Has licence ever been endorsed? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | If "Yes", please give dates and full details. |
| 4.7 FOR OFFICIAL USE ONLY (Authorised Insurance Company Official only to complete this section) | Original/Duplicate/Copy licence inspected. We confirm all details are correct. | | Date inspected: |
| | Remarks: | | Official's Signature: |

| 4. THE DRIVER (Cont.) | | Please give a definite answer to each question | | |
|---|---|---|-----------------------------|------------------------------------|
| 4.8 | State precisely reason for the use of the vehicle at the time of the loss/accident? | | | |
| 4.9 | Was he/she driving with the insured's knowledge and consent? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "No", please give full details |
| 4.10 | Is he/she employed by the insured? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.11 | Was he/she driving under the influence of alcohol and/or drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.12 | Was driver tested for alcohol/drugs? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.12 | Does he/she suffer from any mental or physical defect? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.13 | Has he/she ever been charged or convicted of any motoring offence? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.14 | Has he/she been involved in any motor accident previously? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.15 | Has he/she ever been refused motor vehicle insurance? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.16 | Has he/she ever had special terms imposed on their insurance policy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.17 | Has he/she have a motor policy in his/her own name? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 4.18 | Is he/she being charged by any authority as a result of this accident? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 5. THE ACCIDENT | | Date: | Time: | a.m./p.m. Place: |
| 5.1 | At what time and date was the insured advised of accident? | a.m./p.m. | Date: | By whom? |
| 5.2 | Did the driver admit liability? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 5.3 | Who does the insured believe was to blame and why? | | | |
| 5.4 | Name and address of ALL passengers in insured vehicle. | | | |
| 5.5 | Was driver or any of the passengers injured in the accident? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 5.6 | Do you employ any of them? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 5.7 | Names and addresses of any independent witnesses | | | |
| 5.8 | Name, number and station of the attending/reporting Police Officer. | Name & Rank | Number | Police Station |
| 6. THIRD PARTIES | | Please obtain as much of this information as possible | | |
| 6.1 | Names & addresses of other drivers and persons involved | | | |
| 6.2 | Are any of them in your employ? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 6.3 | Were any of them injured? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | If "Yes", please give full details |
| 6.4 | Give make & Registration numbers of all other vehicles involved | | | |
| 6.5 | Give names of their Insurers and Certificate or Policy number | | | |
| 6.6 | Give details of any damage caused to vehicle and/or property | | | |
| 6.7 | Please give details of any claims | Made against you | To be made by you | |
| Third Party Instructions (Important) | | If any claim is made against you either verbally or in writing, or you are advised at any time of an Intended Prosecution, Inquest or Inquiry, notify this office immediately and forward all documents received. DO NOT ADMIT LIABILITY | | |
| 6.8 | (Please read your policy, especially the policy conditions) | | | |
| DECLARATION | | I/We declare to the best of my/our knowledge and belief that the foregoing particulars are true and correct, and I/we undertake to render the INSURANCE COMPANY every assistance in my/our power in dealing with this matter. I/we also declare that there is no other insurance under which a claim can be made in respect of the accident or loss, and that the said vehicle is my/our property. | | |
| Signature of Policy Holder | | Please print name | | Date |
| Designation | | | | |
| (Company Stamp) | | | | |

SKETCH OF THE ACCIDENT SCENE



Indicate North if certain

PLEASE NOTE: A rough sketch, usually drawn by the driver is of considerable assistance. It may, however be drawn under his/her direction in certain circumstances.

Please include: names, directions, road signs and markings, all vehicles and objects (identified), any measurements taken or estimated, tracks of vehicles, skids, debris and points of impact.

| | | |
|------------------|-----------------------|-----------|
| Sketch drawn by: | Print Name & Initials | Signature |
| Witnessed by: | | Date: |