

Motor Accident Claim Form

IMPORTANT NOTICE

1. No liability is admitted by issue of this form
2. Neither owner nor driver may admit fault or liability for this accident.
3. Do not answer communications about this accident, direct these to the Insurance Company for action.
4. All Questions on this form must be answered.
5. Repairs must not be authorized without prior authority of the Insurance Company

In addition to this form, please submit:

- a. Police Abstract Report.
- b. Copy of the Drivers Driving License.
- c. PSV driving license(where applicable)
- d. Copy of the vehicle logbook.

POLICY HOLDERS' DETAILS

1. NAME _____
2. Telephone/Mobile No _____
3. Postal Address/Postal Code/Town _____
4. Email _____
5. Business Occupation _____

POLICY

1. NUMBER _____
2. Period of Insurance FROM _____ TO: _____
3. Name of hire purchase of financier if any _____
4. Scope of Cover: COMPREHENSIVE TPO TPF&T

Vehicle Details

Registration	Make & Model	Year of Manufacture	Carrying Capacity	Registration No. of Trailer	Carrying Capacity

Registered Owner/Financier

USE

1. State and highlight the exact purpose for which the vehicle was being used at the time of the accident:

2. Was the vehicle on hire? Yes No

COMMERCIAL VEHICLE

1. Description of goods being carried: _____
2. Name of owner of goods: _____
What was the cost of the goods being carried? _____
From whom were the goods purchased from? _____
Please give his/her contact? _____
3. Relationship of the owner of goods with the insured? _____
4. Was Trailer attached? Yes No
5. Weight of load on: a) VEHICLE _____ b) TRAILER(S) _____

DRIVER (EVEN IF IT IS THE INSURED)

1. NAME: _____
2. Actual Date of Birth: _____
3. Address: _____ Telephone No.: _____ Age: _____
4. Business /Occupation: _____
5. Is he/she employed by you? Yes No
6. How long has he /she been in your service? _____
7. How is she /he related to you? _____
8. Was he/she driving with your permission? Yes No
9. How long has he/she been driving motor vehicle? _____
10. Was she /he in any way to blame for the accident? Yes No
11. Has he/she had any previous accident? Yes No
12. If yes, how many and when? _____
13. Has he/she had any conviction for any offence in connection with any motor vehicle or any charges pending?
 Yes No
14. If yes, give details including dates _____
15. Does he/she hold a Full or Provisional Driving License? Full Provisional
16. If Full, state date when driving test was first passed: _____
17. Driving License No. _____
18. Does he/she own a motor vehicle? Yes No
19. If yes, give name & address of Insurer: _____
20. Driver Policy No: _____

ACCIDENT

1. **DATE:** _____ **TIME:** _____ **PLACE:** _____
2. **Type of road surface:** _____ Wet Dry
3. **What lights were showing in your vehicle?** _____
4. What warning did your driver give? _____
5. Estimated speed before accident? Did police take particulars? Yes No
6. If yes, give Constables Number and the Station: _____
7. To which police station was the accident reported to? _____

SKETCH PLAN OF THE ACCIDENT

Draw a sketch plan showing position of the vehicle and persons concerned and the direction in which they were travelling. Also show type and position of traffic signs, skid marks, pedestrian crossing and any other relevant information.

STATEMENT BY DRIVER

STATEMENT BY OWNER/INSURED

DAMAGE TO INSURED VEHICLE

1. State briefly apparent damage(s)

(in case where your vehicle is damaged and you are entitled to claim under your policy, please send us an estimate of repairs)

2. Repairer's/Garage's Name and address: _____
Telephone No/Email: _____
3. Is the vehicle still in use? Yes No

OTHER VEHICLES INVOLVED

Name & Address of owner	Registration	Name of insurer & policy No.	Damaged

PERSONS INJURED

Name(s)	Relationship to the insured	If driver or passenger Reg. No. of vehicle	Apparent Injuries

INDEPENDENT WITNESSES

Name(s)	Address	Telephone

PASSENGER(S) IN YOUR VEHICLE

Name(s)	Relationship to the Insured	Address	Telephone No.

DECLARATION – PLAESE READ CAREFULLY

I DECLARE that these particulars are true and correct and undertake to forward immediately (and unanswered) any correspondence relating to this accident.

Name of Insured	Insured Signature & Stamp	Date