

CLAIM FORM MOTOR ACCIDENT

(1) POLICY NO. : _____ EXPIRY DATE _____

Name of Insured _____

ID NO _____ PIN NO. _____

(tel): _____ (D.O.B): _____ *Date of Birth*

(email): _____

(postal): _____ (code): _____ (city): _____

OCCUPATION / BUSINESS _____

IMPORTANT NOTICE

1. No liability under the policy is admitted by Issue of this form
2. Neither Owner nor driver must admit fault or liability for this Accident
3. Do not answer communications about this Accident, but send them to the Insurers for consideration.
4. All questions on this form must be answered
5. Repairs must not be authorised without prior authority of the Insurers.

(2) VEHICLE

Make & Model _____

HP/CC _____ Year of Manufacture _____

Reg.No.(Vehicle) _____ Carrying capacity : _____

Reg. No. (trailer) _____ Carrying capacity : _____

Name and Address of Owner :

Name : _____

Address _____

(3) VEHICLE USE

State the exact purpose for which the vehicle was being used at the time of the accident.

(4) COMMERCIAL VEHICLE

Description of goods being carried

Name of Owner of goods _____

Was a trailer attached ? Yes No

Weight of load on (a) Vehicle _____

(b) Trailer(s) _____

(5) THE DRIVER

Name of Driver _____

Contact Details: _____

Actual Date of Birth _____ Occupation : _____

Is he employed by you? Yes No

How long has he been in your service? _____

Was he driving with your permission? Yes No

How long has he been driving the Motor Vehicle? _____

Was he in any way to blame for the accident? Yes No

Did he admit liability? Yes No

Has he had any previous accidents? Yes No

If so, how many and approximate dates? _____

(6) THE ACCIDENT

Date _____ Time _____ a.m./p.m.

Place _____

Type of road surface _____

Visibility _____ Wet or Dry? _____

What lights were showing on your vehicle? _____

What warning did your driver give? _____

Estimated speed before _____

Weather conditions _____

Did Police take particulars? Yes No

If so, give Constable's number and station.

To which Police Station was the accident reported?

Has he any conviction for any offence in connection with any motor vehicle or any charges pending? If so, give details including dates

Does he hold a full or provisional licence to drive this vehicle? If full, state date when driving test first passed and the License No.

Does he own a Motor Vehicle?

If so, give name, address of Insurer and the Policy No.

Attached copy Notice of Intended Prosecution if any

(7) PLAN OF ACCIDENT

Draw sketch (stating approximate measurements) showing position of vehicles and persons concerned and the direction in which they were traveling. Also show type and position of traffic signs mark, pedestrian crossings and any other relevant information

(8) STATEMENT BY DRIVER

(9) STATEMENT BY OWNER OR POLICY HOLDER

(10) DAMAGE TO INSURED VEHICLE

State briefly apparent damage

(in all cases where your vehicle is damaged and you are entitled to claim under your policy, please send at once to the Insurers an estimate for repairs)

Repair's Details :

Name, Tel No. and address :

Is the vehicle still in use? Yes No

When and where can it be inspected

(11) OTHER VEHICLES AND PROPERTY DAMAGE

Name and address of Owner	Reg. No.	Name of Insurer	Other property damaged

(12) PERSONS INJURED

Name and address	Relationship to the Policyholder.	If Driver or Passenger Reg.No. of Vehicle	Apparent injuries

(13) INDEPENDENT WITNESS

Name	Tel. No. and Address

PASSENGERS IN YOUR VEHICLE

Name	ATel. No. and Address

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

Date : _____

Signature (Rubber stamp if corporate): _____