



MOTOR VEHICLE CLAIM FORM (NON THEFT)

Full Name(s) of Insured								
Address					State		Postcode	
		Are you registered for GST		No <input type="checkbox"/>	Yes <input type="checkbox"/>	What is your ABN		
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to this Policy?		No <input type="checkbox"/>			Yes <input type="checkbox"/> - Will you be claiming an amount less than 100%?			
		No <input type="checkbox"/>			Yes <input type="checkbox"/> - Specify amount claimed		%	
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?		No <input type="checkbox"/>			Yes <input type="checkbox"/> - Will you be claiming an amount less than 100%?			
		No <input type="checkbox"/>			Yes <input type="checkbox"/> - Specify amount claimed		%	
Contact Numbers		Business Phone No.			Home Phone No.			
		Fax No.			Mobile Phone No.			

Vehicle Details

Make of Vehicle		Year		Registered No.				
Model		Colour		Odometer Reading				
Registered Owner								
Address					State		Postcode	
		Do you owe money on your vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details						
Name of Lender				Account Number				
Address					State		Postcode	

Driver Details

Full Name (Block Letters)								
Address					State		Postcode	
		Business		Private				
Contact Numbers		Facsimile		Mobile				
Relationship to Insured								
Licence Number		Expiry Date		Date of Birth				
How long has the driver been licensed for this type of vehicle?			Years					
Did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident?					No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details			
Did the driver undergo a breath test, breath analysis or blood test?					No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details			
What was the reading?				(Please attach a copy of the certificate)				

Incident Details

Date		Day		Time		am/pm
Where did the incident happen?						
Street		Suburb		Nearest Cross Street		
Road surface: Dry <input type="checkbox"/> Wet <input type="checkbox"/> Loose <input type="checkbox"/>						
At the time of the accident the insured vehicle was: Parked <input type="checkbox"/> Stationary <input type="checkbox"/> Moving <input type="checkbox"/> Speed <input type="text"/>						
Traffic controls: None <input type="checkbox"/> Stop sign <input type="checkbox"/> Traffic Lights <input type="checkbox"/> Roundabout <input type="checkbox"/> Give way sign <input type="checkbox"/> Other <input type="checkbox"/>						
Number of other vehicles involved <input type="text"/>						
If applicable, what type of goods were being transported at time of loss? <input type="text"/>						
What happened?						
Who was at fault?						
SKETCH DIAGRAM OF ACCIDENT 1. Name streets 2. Indicate direction of travel 3. Your vehicle <input checked="" type="checkbox"/> 4. Other vehicle <input type="checkbox"/>						

Damage to Your Vehicle

Are you claiming for the damage to your vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Was the vehicle towed? No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details			
Name of tow company <input type="text"/>			
Where was it towed? <input type="text"/>		Distance towed	Kms <input type="text"/>
Where is the vehicle now? <input type="text"/>			
SKETCH DIAGRAM Shade in damage to vehicle Indicate point of impact (X)			

Owner of Other Vehicle

Full Name (Block Letters)	<input type="text"/>				
Address	<input type="text"/>			State	<input type="text"/>
	<input type="text"/>			Postcode	<input type="text"/>
Contact Numbers	Business	<input type="text"/>	Private	<input type="text"/>	<input type="text"/>
Insurance Co.	<input type="text"/>				

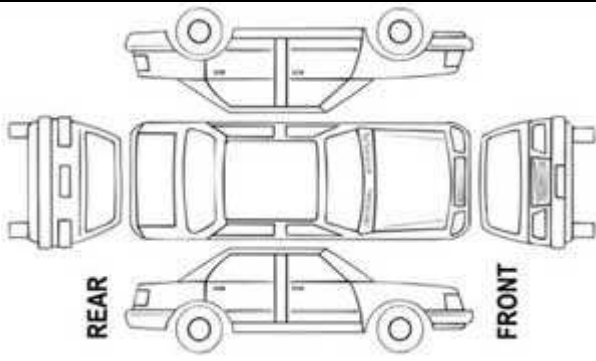
Driver of Other Vehicle

Full Name (Block Letters)								
Address				State		Postcode		
Contact Numbers	Business			Private				
Date of Birth				Driver's Licence Number				
Was the owner in the vehicle at the time of the accident?							No <input type="checkbox"/>	Yes <input type="checkbox"/>
IF THERE IS MORE THAN 1 OTHER VEHICLE INVOLVED PLEASE ATTACH DETAILS								

Other Vehicle

Registration No.		Year of Manufacture		Make of vehicle	
Model			Colour		

Damage to Other Vehicle

SKETCH DIAGRAM Shade in damage to vehicle Indicate point of impact (X)	
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Other Parties

Give details of pedestrians, owners of property or owners of animals involved.							
Full Name (Block Letters)							
Address				State		Postcode	

Police

Did a Police Officer attend the accident scene, No <input type="checkbox"/> Yes <input type="checkbox"/> or did you report the incident to the police? No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details					
Name				Rank	
Station					
Date of Report			<i>(Please attach a copy of the Police Report)</i>		

Witness(es) Details

Full Name (Block Letters)								
Address				State		Postcode		
Contact Numbers	Business			Private				
Was this witness in the insured vehicle?							No <input type="checkbox"/>	Yes <input type="checkbox"/>
Full Name (Block Letters)								
Address				State		Postcode		
Contact Numbers	Business			Private				
Was this witness in the insured vehicle?							No <input type="checkbox"/>	Yes <input type="checkbox"/>

