

# MOTOR VEHICLE CLAIM FORM

Claim No:
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## 1. Policyholder

Full Name and Address of Policyholder ..... ..... .....		Occupation: .....	
		Telephone No:	Home (.....) .....
			Bus. (.....) .....
Insurer:	Policy No:	Expiry Date:	/ /
For what purpose was the vehicle being used?			

## 2. Insured Vehicle

Make & Model			
Body Type:		Year of Manufacture:	
Registration No:		Engine No:	
V.I.N. No		Expiry Date of Registration:	/ /20
Name & Address of Finance Co. if applicable	..... .....		
Have there been any engine, body or transmission modifications from the manufacturer's original specifications or any accessories added?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please give details: ..... .....

## 3. Driver (Please complete these details in respect of the person in charge of the vehicle at the time of the accident)

Full Name and Address of Driver ..... ..... .....		Occupation: .....	
		Sex (M or F).....	
		Date of Birth: / /	
Drivers Licence No:		State of issue:	
How long has the driver held a motor vehicle drivers licence?	yrs	Expiry Date of Licence: / /	
Was the vehicle being used with the full knowledge and consent of the policyholder?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
What is the relationship of the Driver to the Policyholder?	<input type="checkbox"/> Self <input type="checkbox"/> Relative <input type="checkbox"/> Employee <input type="checkbox"/> Friend <input type="checkbox"/> Other If Other, please describe:.....		
Have you (the Policyholder) or the driver of the vehicle at the time of the accident:	(i) been involved in any previous motor vehicle accident in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) been charged with any offence in relation to the use of a motor vehicle in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (iii) had any insurance declined or cancelled, been refused renewal of an insurance or had special terms imposed in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", to (i), (ii) or (iii), please give details below:		
<b>Name</b>	<b>Date</b>	<b>Particulars</b> (eg, name of insurance company, details of charges etc)	
	/ /		
	/ /		
	/ /		
Was the driver under the influence of any drug or alcohol at the time of the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No		