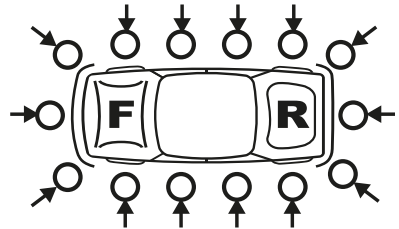


MOTOR CLAIM FORM

Claim No.:											
1. THE INSURED											
Name:								VAT No.:			
Home Address:								Tel. No.:			
Business Address:								Tel. No.:			
Email Address:								Cell. No.:			
Occupation:											
2. THE POLICY											
Policy No:										Date of Birth / ID. No:	
Renewal Date:						Excess applicable: \$					
Coverage:										Insured Value: \$	
Is premium paid? <input type="radio"/> YES <input type="radio"/> NO If not, why not?											
3. THE INSURED VEHICLE											
Registration No:				Year:		C.C.		Engine No:			
Make & Model:						Colour:		Chassis.:			
Is Vehicle:	Left Hand Drive:		Car		Van:	Motor Cycle:		Truck:		Special Licence:	
Exactly what was vehicle being used for?											
Name of Owner of vehicle:											
Was the vehicle being used with the owner's consent? <input type="radio"/> YES <input type="radio"/> NO											
Specify any mortgage/hire purchase agreement on your vehicle:											
How many passengers were being carried?						Were they fare paying? <input type="radio"/> YES <input type="radio"/> NO					
If goods were being carried, state: a) Owner:											
b) Description:											
4. THE DRIVER											
Name:								<input type="radio"/> Male <input type="radio"/> Female			
Home Address:								Tel. No.:			
Business Address:								Tel. No.:			
Occupation:								Date of Birth / ID. No.:			
Is the Driver employed by you? <input type="radio"/> YES <input type="radio"/> NO								State date licence originally passed:			
Driver's Licence No: <i>(Please attach Photocopy)</i>								Date of Issue:			
Type of Licence:								Date of Expiry:			
What is the relationship of the driver to the policyholder:											
Driver details (If different from insured)											
Name:				Address:				Cell No.:			
Has the Driver any motoring convictions/offences or licence endorsements/suspensions? <input type="radio"/> YES <input type="radio"/> NO (Give details)											
Has the Driver had any previous accidents? (Give details)											
Has the Driver ever been refused any type of insurance? <input type="radio"/> YES <input type="radio"/> NO						Has the Driver been drinking any alcohol / taking drugs? <input type="radio"/> YES <input type="radio"/> NO					
Does the Driver own a vehicle? <input type="radio"/> YES <input type="radio"/> NO Where is it Insured?										Reg. No.:	
Has the Driver any physical infirmity, or defective vision or hearing, or lost a limb or any eye? <input type="radio"/> YES <input type="radio"/> NO											
If yes, what?											
5. THE ACCIDENT OR LOSS											
Date:			Time:			Place:					
Did the Police go to the scene? <input type="radio"/> YES <input type="radio"/> NO						Were measurements taken? <input type="radio"/> YES <input type="radio"/> NO					
Police's Name/No:						Police Station to which reported:					
Was either party warned for prosecution (If so whom)? <input type="radio"/> YES <input type="radio"/> NO											
Was the road surface paved or unpaved? <input type="radio"/> Paved <input type="radio"/> Unpaved											
Condition of road:						Weather Conditions:					
What was your speed a) before accident b) at the time of accident:											
Were your lights turned on? <input type="radio"/> YES <input type="radio"/> NO						Did you give any warning or signal? <input type="radio"/> YES <input type="radio"/> NO					
Whom do you consider responsible for the accident? Name:											

6. DAMAGE TO VEHICLE

State damage to vehicle: (and indicate on drawing) Point of Impact: Indicate by ⊗



Where can vehicle be inspected?

Is vehicle still in use? YES NO

Have you obtained an estimate for repairs? (if yes please provide copy)

7. PERSONS CONNECTED WITH THE ACCIDENT (AND PERSONAL INJURY)

• Please provide the following information for all passengers in your vehicle:

• Name: _____ Address: _____

• Tel. No.: _____ Age: _____ Where treated: _____

• Involvement: _____ Nature of injuries: _____

• Name: _____ Address: _____

• Tel. No.: _____ Age: _____ Where treated: _____

• Involvement: _____ Nature of injuries: _____

• Please provide the following information for other persons injured or other witnesses to the accident:
(Whether person(s) was Driver or Passenger or Other (Pedestrian etc.)

• Name: _____ Address: _____

• Tel. No.: _____ Age: _____ Where treated: _____

• Involvement: _____ Nature of injuries: _____

• Name: _____ Address: _____

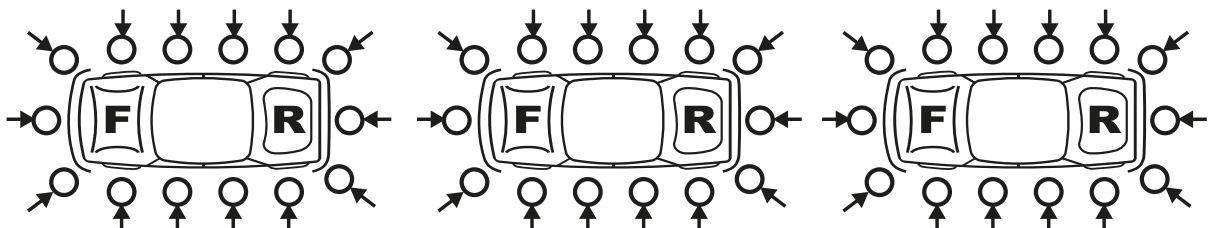
• Tel. No.: _____ Age: _____ Where treated: _____

• Involvement: _____ Nature of injuries: _____

8. OTHER VEHICLE OR PROPERTY CONNECTED WITH THE ACCIDENT

PARTICULARS	VEHICLE 1	VEHICLE 2	VEHICLE 3
• Registration No.:			
• Make & Model:			
• Name of Owner:			
• Address:			
• Name of Insurer:			
• Driver's Name:			
• ID. No. D.O.B.			
• Address:			
• Name of Insurer:			
• Occupation:			
• Tel. No.:			
• Description of Damage:			
• Description of Damage to other Property:			
• Name of Owner:			

Indicate by ⊗ the Point of direction of Impact:



Kindly indicate by ticking the appropriate box, whether this report is only a notification or additionally, if you propose claiming under the policy.

ALL COMMUNICATIONS ABOUT THE ACCIDENT MUST BE IMMEDIATELY FORWARDED TO THE COMPANY.

I/We hereby declare that to the best of my/our knowledge and belief, the foregoing statements are fully and truly made.

Date: _____ Insured's Signature: _____

DIAGRAM OF ACCIDENT

