

Please complete fully and return immediately



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MOTOR POLICIES CLAIM FORM

(NO LIABILITY IS ADMITTED BY THE ISSUE OF THIS FORM)

POLICY HOLDER:

NAME: _____
ADDRESS: _____
TRADE OR OCCUPATION: _____

CLAIM NO.: _____
POLICY NO.: _____
TYPE OF COVER: _____
PRIVATE PHONE NO.: _____
BUSINESS PHONE NO.: _____

Do you hold more than one Policy indemnifying you in respect of this occurrence? _____

PARTICULARS OF VEHICLE

Make:	HP:	Date of Make:	Regn No.:
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For what purpose was it being used at time of accident? _____

Is the vehicle your property? Yes No If not, state Owner: _____

How many of your vehicles were in use at time of accident? _____

If used for carriage of goods, state whether for own trade delivery? _____

Give particulars of nature and weight of goods carried: _____

If used for passenger hire, state how vehicle was so hired: _____

DRIVER

Name of Driver: _____ Age: _____

Address: _____

Licence No.: _____ Date of Issue: _____

Is he a paid driver in your service? Yes No

How long has he been in your employ? _____

Was he acting within the scope of his authority? Yes No

Give all details of driver's previous accidents? _____

If a relation or friend driving, does he/she own a car? Yes No

If so, name his/her Insurance Company: _____

WITNESSES: Give Names and Addresses of:-

PASSENGERS (if any)		OTHER WITNESSES
State whether carried for hire or reward		

Did a Police Constable witness accident, or TAKE PARTICULARS? _____ If so, give Number and Station _____

PERSONAL INJURY, DAMAGE TO OTHER PERSONS' VEHICLES OR PROPERTY

Name and Address of Owner of other Vehicle (if applicable) _____

Regn. No. of other vehicle involved: _____ Damage to other vehicle: _____

Name and Address of injured person or persons: _____

Nature of injuries sustained: _____

To what Hospital, if any, was injured person taken? _____

Damage to property _____

Has any claim been made on you? _____ If so, verbally or in writing? _____

Please forward at once any communication you may have received unanswered

DAMAGE TO POLICYHOLDER'S VEHICLE

Have you obtained an Estimate for Repairs? _____

If so, from whom? _____ Address: _____

Amount of Estimate _____ (Please forward if in writing)

Where can vehicle be inspected? _____

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CIRCUMSTANCES OF ACCIDENT

Date of accident: _____ Hour: _____ Please state a.m. or p.m.

Place where accident occurred? _____

Was your car on near side of road? _____ { If so, how far from kerb? _____
If not, on what part of the road was it? _____

Condition of Road, wet or dry _____ Did your driver give warning and how? _____

Did the driver of the other vehicle (if any) give warning and how? _____

If the accident occurred after lighting-time up, was { a) your car lighted and how? _____
b) the other vehicle lighted and how? _____

What was the speed of your car { a) immediately before the impact? _____
b) at the moment of impact? _____

In your opinion, who was to blame for the accident? _____

Give a full description of exactly how the accident occurred

Please make a rough sketch (stating approximate measurements) showing position of vehicles and persons concerned and the direction in which they were travelling

I/we hereby declare the foregoing particulars and statements to be true in every respect.

Date: _____ POLICYHOLDER'S SIGNATURE: _____