

# MOTOR VEHICLE CLAIM FORM

This form must be completed by the driver. Please answer all questions. If not applicable, please write N/A

Claim No .....  
Insurance Coy .....  
Branch .....  
Policy No .....  
Due Date .....  
Excess .....

Pursuant to the Privacy Act 1993 the following is brought to your attention:

- (a) This claim form collects personal information about you;
- (b) The information is collected to evaluate your claim;
- (c) The intended recipient of the information is .....  
(hereinafter called "the Company" and is being held by them at .....
- (d) The collection of this information is required pursuant to the terms of your insurance policy;
- (e) The failure to provide this information may result in your claim being declined;
- (f) You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993.

## 1. POLICYHOLDER

## INSURED VEHICLE

Surname of Insured OR name of company	MAKE:
First Names of Insured	MODEL:
Address:	TYPE: (e.g. van, car, artic, flat-top etc)
	YEAR:                                  REG NO
Contact Telephone Numbers (Hm)                                  (Bus)	Has the vehicle been modified in any way:
Name of any other party with financial interest in the vehicle:	Is the vehicle a used import : Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there any other insurance on the vehicle or accessories: Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the vehicle a current Certificate of Fitness : Yes <input type="checkbox"/> No <input type="checkbox"/>

## 2. PERSON DRIVING OR IN CHARGE OF THE INSURED VEHICLE (to be completed, even if parked)

Full Name (Mr/Mrs/Miss/Ms): Address: Occupation: Your relationship to policyholder:	Date of Birth ...../...../.....	<b>Driver Licence &amp; Type:</b> <input type="checkbox"/> Full <input type="checkbox"/> Restricted <input type="checkbox"/> Learner Number..... Issue Date ..... Classes ..... Years Held .....
	Telephone: Home.....	
	Bus .....	
	Employer .....	
1. Was the vehicle being driven with the owner's consent?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "NO" please provide details .....	
2. Is he/she the main driver of the Insured vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/> If "NO" please provide details .....	
3. If not the Policyholder, do you own a vehicle? (name of insurance co):	Yes <input type="checkbox"/> No <input type="checkbox"/> If "YES" please provide details .....	
4. Did driver consume liquor and/or drugs (including medication) within 24 hours prior to the accident?	Yes <input type="checkbox"/> No <input type="checkbox"/> .....	
5. Did the police attend?	Yes <input type="checkbox"/> No <input type="checkbox"/> .....	
6. Was a breathalyser, or blood test, or any other such test done?	Yes <input type="checkbox"/> No <input type="checkbox"/> .....	
7. During the past 5 years, have you:		
(i) Been convicted of any offence other than parking (type and penalty):	Yes <input type="checkbox"/> No <input type="checkbox"/> .....	
(ii) Had any other accident, loss of claim in connection with any motor vehicle (brief details of year/cost/insurance coy)	Yes <input type="checkbox"/> No <input type="checkbox"/> .....	

**3. DETAILS OF OTHER PERSONS**

<b>Passengers in your vehicle</b>	<b>Independent Witnesses</b>
Name .....	Name .....
Address .....	Address .....
Telephone .....	Telephone .....
Name .....	Name .....
Address .....	Address .....
Telephone .....	Telephone .....
<b>Driver/Owner of other vehicle or property</b>	<b>Driver/Owner of other vehicle or property</b>
Name .....	Name .....
Address .....	Address .....
Telephone ..... Insurance Coy .....	Telephone ..... Insurance Coy .....
Details of vehicle/property .....	Details of vehicle/property .....
Registration Number .....	Registration Number .....

**4. DETAILS OF LOSS OR ACCIDENT (Please continue on a separate sheet, if necessary)**

Date ..... Time ..... Am / pm (delete one)

Location (e.g. street) ..... Suburb/Town .....

Weather :             Rain             Overcast             Fog             Bright Sun             Clear Night

Road                     Sealed             Metal             Wet             Dry

What speed was in force?    50 km/hour     100 km/hour     Other

What was your speed – prior to breaking ..... / at impact ..... Please state reason for journey .....

Describe in detail how the accident occurred: .....

.....

.....

What in your opinion, caused the accident: .....

**5. DAMAGE TO INSURED VEHICLE (NB Do not proceed with repairs without the Company's authority)**

Describe damage .....

Repairer ..... Telephone ..... Estimate \$.....

If not at above, date of repair ..... OR where can vehicle be inspected .....

**6. SKETCH PLAN OF ACCIDENT (Please continue on a separate sheet if necessary)**

Indicate street names; direction of vehicles. Your vehicle \_\_\_\_\_ Other vehicle \_\_\_\_\_

**DECLARATION**

Note : Failure to provide full and truthful information could result in the Claim being declined.

We authorise the disclosure of my/our personal information held by other parties which relate to this claim.

We agree to The Company disclosing my/our personal information regarding this claim to:

- a) Other members of the Insurance Industry; and
- b) Parties who have a financial interest in the subject matter of the claim.

All the information and answers given on this claim are correct. We authorise The Company to act on my/our behalf.

Policyholder's signature ..... Date .....  
(if a company, state capacity)

Drivers signature ..... Date .....