

Motor Vehicle Accident Report Form

Claim No.

You should answer all questions. If you tick the shaded box please give details in the spaces provided. If you have any queries on your responses please call us. This form should be completed and returned to us as soon as possible.

1 INSURED'S DETAILS

Name:	
Home Address:	Tel. No: <input type="text"/>
	Cell No: <input type="text"/>
Business Address:	Tel. No: <input type="text"/>
	Email: <input type="text"/>
Occupation:	Date of Birth/ ID No:

2 THE POLICY

Policy No.:	Renewal Date:	Excess applicable:
Coverage: Comprehensive <input type="checkbox"/> Third Party <input type="checkbox"/> TP Fire & Theft <input type="checkbox"/>		Insured value:
Is your premium paid? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If not, give details:		Agreed Value Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Specify any mortgage/ hire purchase agreement on your vehicle:		

3 VEHICLE DETAILS

Registration No.:	Year:	c.c.	Engine No.
Make & Model:			Chassis No:
Is vehicle: Left hand drive: <input checked="" type="checkbox"/> Van: <input type="checkbox"/> Motor Cycle: <input type="checkbox"/> Truck: <input type="checkbox"/> Special Licence: <input type="checkbox"/>			
At the time of the accident exactly what was vehicle being used for? Private use <input type="checkbox"/> Business use <input checked="" type="checkbox"/> Other use <input checked="" type="checkbox"/>			
Name of owner of vehicle:	Was vehicle being used with owner's consent? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
How many passengers were being carried?	Were they fare paying? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
If goods were being carried, state:	(a) Owner		
	(b) Description		

4 DRIVER'S DETAILS - IF THE SAME AS ABOVE GIVE ONLY THOSE DETAILS NOT NOTED ABOVE

Name:	Male <input type="checkbox"/> Female <input type="checkbox"/>	
Home Address:	Tel.No: <input type="text"/>	
	Cell No: <input type="text"/>	
Business address:	Tel.No: <input type="text"/>	
	Email: <input type="text"/>	
Occupation:	Date of Birth:	ID No.:
Is the driver employed by you? Yes <input type="checkbox"/> No <input type="checkbox"/>	State year licence originally passed:	
Driver's Licence No: (Please attach photocopy)	Date of Issue:	
Type of licence:	Date of expiry:	

4. DRIVER'S DETAILS Continued

What is the relationship of the driver to the policy holder?

Has the driver any motoring convictions/offenses or licence endorsements/suspensions? Yes No If yes, give details:

Has the driver had any previous accidents? Yes No If yes, give details:

Has the driver ever been refused any type of insurance? Yes No If yes, give details:

Had the driver been drinking/taking drugs? Yes No

Does the driver own a vehicle? Yes No Where is it insured?

Has the driver any physical infirmity, or defective vision or hearing, or lost a limb or any eye? Yes No If yes, give details:

5 ACCIDENT OR LOSS

Date: _____ Time: _____ Location: _____

Did the police go to the scene? Yes No Were measurements taken? Yes No Police station to which reported:

Policeman's Name/No: _____

Was either party warned for prosecution? Yes No If so, whom?

Was the surface paved or unpaved? _____ Condition of road: _____ Weather Conditions: _____

What was your speed (a) before the accident: _____ (b) at the time of the accident: _____

Were your lights turned on? _____ Did you give any warning or signal? _____

6 DAMAGE TO THE INSURED VEHICLE

Is the vehicle still in use? Yes No Where can vehicle be inspected?

Have you obtained an estimate for repairs? (if so, please provide copy) Yes No

7 PERSONS CONNECTED WITH ACCIDENT (AND PERSONAL INJURY)

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

PASSENGER

Name _____ Email: _____
Address _____ Tel. Home: _____
Work: _____

Were they injured in the accident? Yes No If yes, state nature of injuries:

Were they treated for injuries: Yes No If yes, give full details:

PASSENGER

Name _____ Email: _____
Address _____ Tel. Home: _____
Work: _____

Were they injured in the accident? Yes No If yes, state nature of injuries:

Were they treated for injuries: Yes No If yes, give full details:

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

Please provide the following information for other persons injured or other witnesses to the accident:

OTHER PERSONS

Name Tel. Home:

Address Work:

Were they injured in the accident? Yes No If yes, state nature of injuries:

Were they treated for injuries: Yes No If yes, give full details:

Were they: Passengers Driver Other

OTHER PERSONS

Name Tel. Home:

Address Work:

Were they injured in the accident? Yes No If yes, state nature of injuries:

Were they treated for injuries: Yes No If yes, give full details:

Were they: Passengers Driver Other

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OTHER VEHICLES CONNECTED WITH THE ACCIDENT

Particulars	Vehicle 1	Vehicle 2	Vehicle 3
Reg. No.			
Make & Model:			
Name of Owner:			
Address:			
Tel. No:			
Email:			
Name of Insurer:			
Driver's Name:			
ID No./Date of Birth:			
Address:			
Occupation:			
Tel. No:			
Email			

Description of damage:

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OTHER PROPERTY DAMAGE CONNECTED WITH THE ACCIDENT

Property

Damage to other Property

Owner

Tel. No.:

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DRIVER'S STATEMENT

Give details of the accident or loss as it occurred and where were you coming from, going to, what you did, see/hear, what did you do?

I/We hereby declare that the foregoing particulars by me/us are true in every respect:

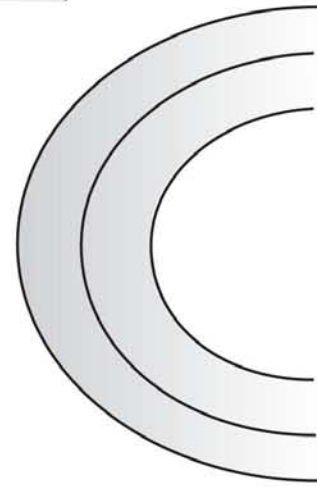
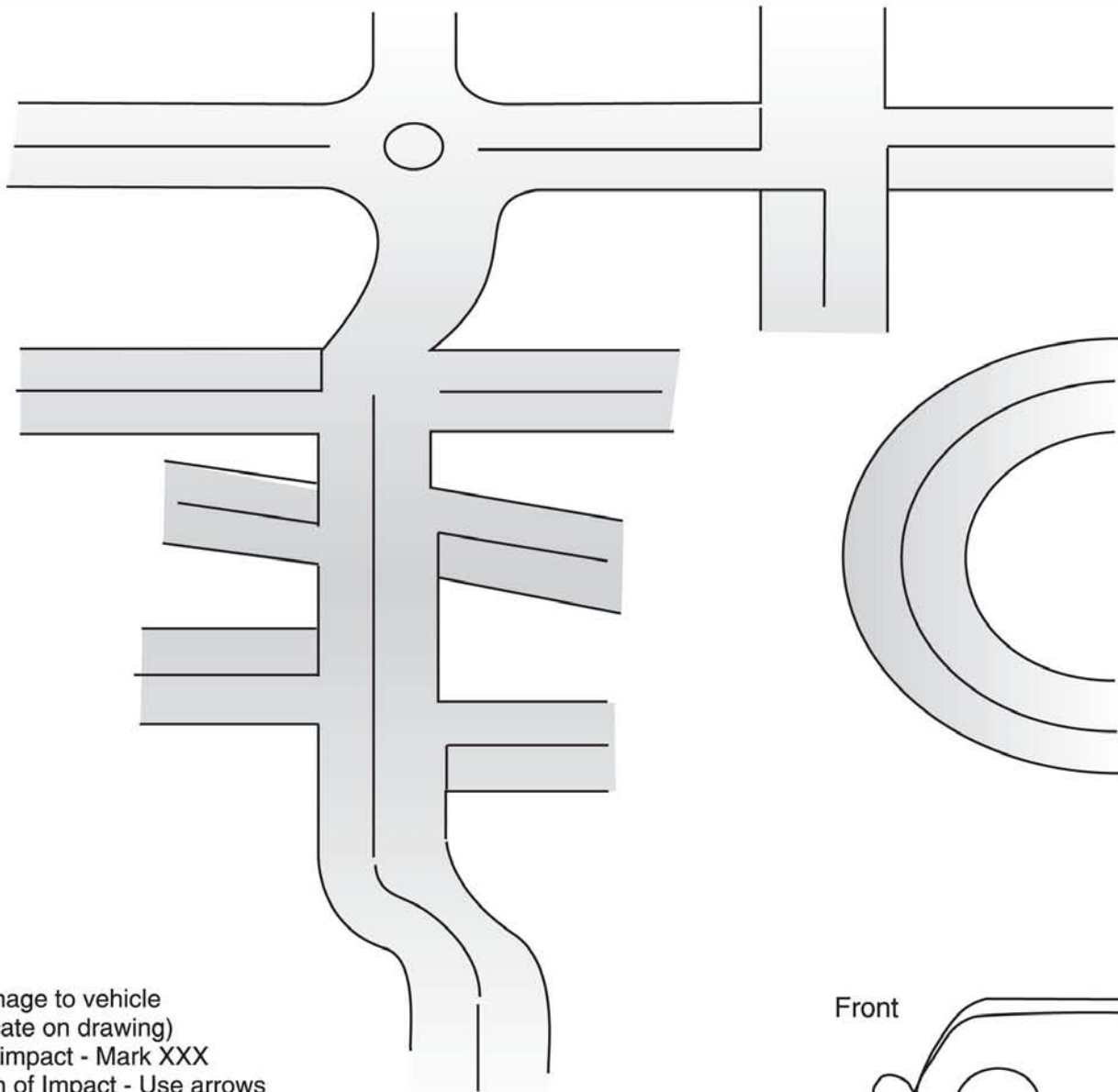
Driver's signature: _____ I.D. _____ Date: _____

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DECLARATION & SIGNATURE

ALL COMMUNICATION FROM OR ON BEHALF OF ANY CLAIMANT MUST BE FORWARDED TO US IMMEDIATELY.
I/WE HEREBY DECLARE THAT THE FOREGOING PARTICULARS GIVEN BY ME/US ARE TRUE IN EVERY RESPECT.

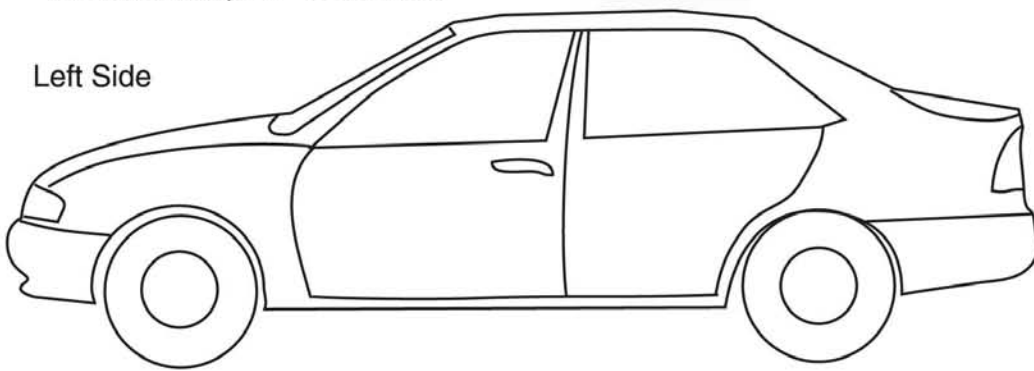
Insured's Signature: _____ Date: _____



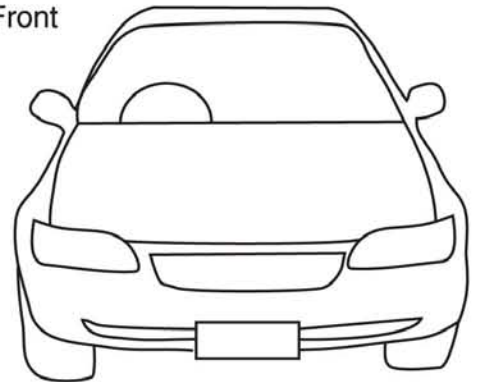
State damage to vehicle
(and indicate on drawing)

- Point of impact - Mark XXX
- Direction of Impact - Use arrows

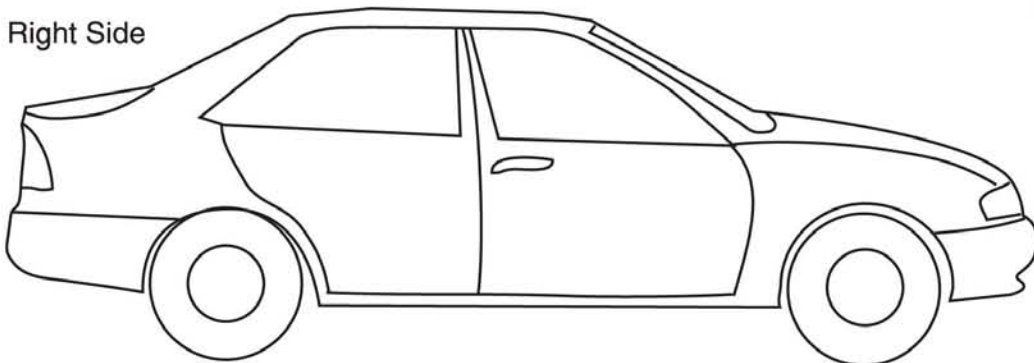
Left Side



Front



Right Side



Back

