

MOTOR VEHICLE CLAIM FORM

Claim Number:

1. Policyholder

Full Name and Address of Policyholder	Occupation: Telephone Numbers: Business Hour (....) After Hour (....)	
Insurer:	Policy No:	Expiry Date: / / 20.....
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 <i>If yes, please give details:</i>	
.....	

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: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: / /	
Drivers Licence No:	State of issue:	
How long has the driver held a motor vehicle drivers licence? years	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:		
Name	Date	Particulars (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	
Please state what drugs or how much alcohol was consumed by the driver in the 12 hours prior to the accident:	
Did the driver undergo a breath test?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what was the reading?
Has the driver's motor vehicle licence ever been cancelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give details:	

4. Accident Date

Date of accident: / / 20.....	Time of accident: am/pm
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5. Description of Accident









Name of street where accident occurred
If at an intersection, names of intersecting streets
Suburb, Town, City	.....
State clearly and fully how the accident occurred <i>(if insufficient space, attach separate statement)</i>	..... ..... ..... .....
Was the street wet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the other party admit liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give details:

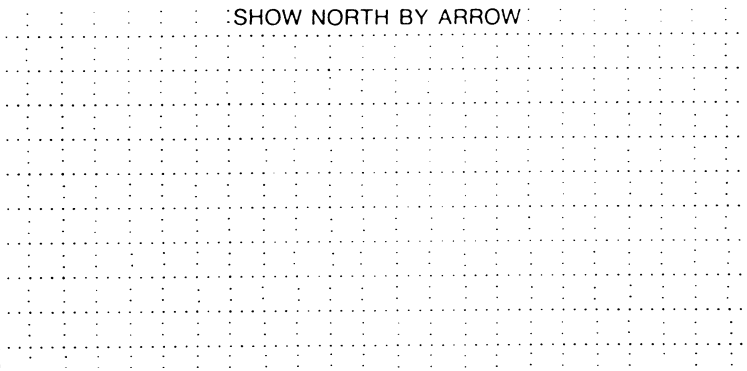
Please draw sketch showing position of all vehicles and pedestrians at the time of the accident:

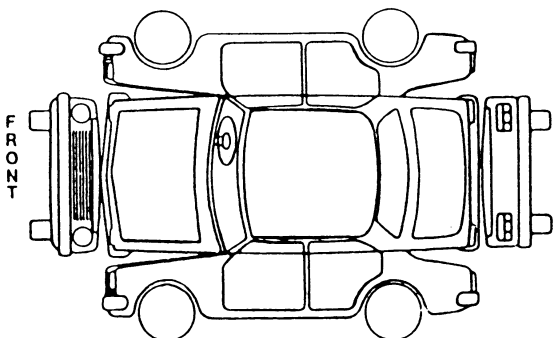
Please draw Sketch showing position of all Vehicles and Pedestrians at the time of the accident. Show also position of all Traffic Lights, Signs, and Pedestrian Crossings.

SHOW NORTH BY ARROW

SYMBOLS

Street Intersection		Pedestrians	
Curved Street		Stop Sign	
Your Vehicle		Give Way Sign	
Other Vehicle		Traffic Lights	



Did the driver suffer any injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, was medical attention required?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, state name and address of doctor or hospital
Please indicate Insured Vehicle's speed immediately prior to accident	<input type="checkbox"/> Stationary <input type="checkbox"/> Under 30 km/h <input type="checkbox"/> 30-60km/h <input type="checkbox"/> 60-80km/h <input type="checkbox"/> 80-100km/h <input type="checkbox"/> Over 100km/h
Please indicate Other Vehicle's speed immediately prior to accident	<input type="checkbox"/> Stationary <input type="checkbox"/> Under 30 km/h <input type="checkbox"/> 30-60km/h <input type="checkbox"/> 60-80km/h <input type="checkbox"/> 80-100km/h <input type="checkbox"/> Over 100km/h
Was the vehicle towed from scene of accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give name of towing contractor
Did you authorise this towing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Where can the vehicle be inspected? <i>(If at a repairer's premises - name & address of repairer)</i>	..... ..... ..... Telephone Number:
Estimated Cost of Repairs <i>(including parts)</i>	\$ Repair Quotation No:
Please indicate areas of damage to insured vehicle	

6. Police

Date reported to Police	..... / ..... / 20.....	Time reported to Police	..... am/pm
Did the Police attend the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: (i) From which Police Station? (ii) Name of Officer		
Did the Police indicate which driver was at fault?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: (i) Name of driver charged or cautioned (ii) Nature of charge or caution		

6. Other Parties (Please complete this section if any other vehicles or property involved)

Number of other vehicles involved	.....
Owner's name and address	..... ..... ..... ..... .....
Licence Number	.....	Age
Make and Model of Vehicle	.....
Registration Number	.....
Driver's name and address	..... ..... ..... Postcode.....	

<p>Please give particulars of damage to other party's vehicle and/or property</p> <p><i>NB: (If more than one third party involved, please provide similar particulars on a separate sheet)</i></p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
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8. Witnesses

Passengers in Insured Vehicle	Names	Addresses
	<p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
Independent Witnesses	Names	Addresses
	<p>.....</p> <p>.....</p> <p>.....</p>	<p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

9. ABN Details

Are you a registered business?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	What is your ABN?	ABN No:
What percentage of GST in your premium did you claim as an Input Tax Credit for the period of insurance in which this loss occurred?%				

10. Declaration

<p>The information and answers given above are a true and complete statement of the facts and matters relating to the happening for which this claim is made, and no information likely to affect this claim has been withheld. I authorise my Insurer to undertake on my behalf whatever actions are necessary to indemnify me within the terms of my policy including if necessary, removal of my vehicle to alternative premises to enable repairs to be carried out by a qualified Motor Body Repairer. I understand that this claim may be refused if information is untrue, inaccurate or concealed.</p> <p>I expressly agree that the information given by me is provided with my full knowledge and consent and further agree to hold harmless and indemnify Direct Insurance Brokers in the event of any action or matter that may be taken by any party pursuant to the Privacy Act 1988 (Cth).</p>	
Driver's Signature	Date:/...../.....
Policyholder's Signature	Date:/...../.....