MOTOR ACCIDENT CLAIM FORM

Policy Details

Insurer	
Broker	
Policy No.	

Insured details

Title, Initials & Surname				
Occupation				
Identity Number				
Residential Address				
Employer Name				
Work Address				
Telephone Numbers	Work		Cell	

Registered Owner of Vehicle

Title, Initials & Surname				
Occupation				
Identity Number				
Residential Address				
Employer Name				
Work Address				
Telephone Numbers	Work		Cell	

Vehicle Information

Date Purchased	
From Whom Purchased	
New or Second Hand	
Make	
Model	
Year of Manufacture	
Registration No.	

MOTOR ACCIDENT CLAIM FORM

Chassis No. (VIN)	
Engine No.	
Kilos Completed	

Financing Details

Is Vehicle Currently Subject to And if so?	Instalment-Sale Agreement	Yes ◯	No ◯
	Lease Agreement	Yes ◯	No ◯
	Any type of Agreement	Yes ◯	No ◯
Name of Finance Company and Telephone No.			
Date agreement entered into			
Amount Outstanding			
Account Number			

Damage

Damage to own Vehicle			
Estimates to Repair (attach quotations)			
Repairer's Name		Repairer's Telephone No.	
State where the vehicle can be inspected			

Police

Police Station		Police officer who recorded details of incidents name	
Telephone			
Reference			
Date Reported		Time	

Driver Details

Title, Initials and Surname	
Occupation	
Identity Number	
Residential Address	
Employer Name	
Work Address	

MOTOR ACCIDENT CLAIM FORM

Email Address					
Telephone Numbers	Work		Cell		
Licence Details	Code		Place of Issue		Date of Issue	
State purpose for which vehicle was being used for					
Was he/she driving with your permission?	Yes ◯	No ◯			
Is he/she in your employ?	Yes ◯	No ◯			
Is he/she an owner of another vehicle?	Yes ◯	No ◯			
If yes provide the name of insurer an policy number					
Details of any convictions for motoring offenses					
Has licence ever been endorsed?	Yes ◯	No ◯			
Has he/she any physical defects? (if yes state details)	Yes ◯	No ◯			
Details of previous accidents					

Passenger Details

Were there any passengers in the insured vehicle, if so please state their name adress and telephone number below.

Name	Address	Telephone Number

Are they employees?	Yes ◯	No ◯
For what purposes were they being transported?		

Witness Details

Name	Address	Telephone Number

MOTOR ACCIDENT CLAIM FORM

Other Party Details

Registration No.	Make and Model of Vehicle	Name and Address of Owner and Driver	Telephone Number	Damage Details
Damage to property other than vehicles (indicate damage)				

Injuries

Name of injured person	Relationship to injury (e.g. driver)	Details of Injury	Name of Hospital

Circumstances of Loss

Description of Accident	Date			
	Time			
	Place			
	Speed before accident		Speed on impact	
	Wheather condition (at time of accident)		Visibility	
	Road Surface		Width of road	
	State is vehicle lights were on		Street lighting	
	Any warning given by you?		Tested for Alcohol/Drugs	
Description of Incident				

MOTOR ACCIDENT CLAIM FORM

Was a load being transported at the time of the accident?		Yes ◯	No ◯
If yes, what was the commodity?			

Sketch of Accident (if necessary use a seperate page)

Were there any passangers in the insured vehicle, if so plaese state their name adress and telephone number below.
Please indicate clearly the point of impact and indicate direction of travel by arrows. Give details of any road signs or warning signs in the vicinity of scene of the accident.

Declaration

I / We hereby declare the forgoing particulars to be true and accurate in every respect.

Dated ..... / ..... /20 .....

Signed at ..... on this ..... day of .....

Name: ..... Witnessed by: .....

Capacity: ..... Signature: .....

Driver Signature: ..... Name: ..... Tel No. : .....