



MOTOR ACCIDENT CLAIM FORM

PLEASE NOTE YOU ONLY HAVE 30 DAYS FROM DATE OF ACCIDENT TO GET ALL DOCUMENTATION TO US

	Broker		Insurer	
INSURED	Full Name / Company Name		Policy Number	
	Identity Number Vat Registration Number			
	Address		Contact Numbers	
VEHICLE	Make & Model		Year	
	Registration		Value	
	In who's name is vehicle registered?			
DAMAGE	Date & Time of accident		Place of accident	
	Damage to own vehicle			
	Estimate for repairs (or attach quotation)	R	Where can the vehicle be inspected?	
	Repairers Name, Address & Telephone Number			
DRIVER	Full Name		Occupation	
	Address		Relationship to Insured	
	License Number		Identity Number	
	Validity Period		License Code	
	License Restrictions		First Issue	
	Full License		Learner Licence	
	State fully the purpose for which the vehicle was used	Private / Professional / Business	Was he/she driving with your permission?	
	Was he/she in your employ?		Details of any convictions for motoring offences.	
	Details of previous accidents		Is he/she the owner of another vehicle? If yes, give name of insurer and policy number.	
	Has he/she any physical defects?		Has license ever been endorsed?	
PASSENGERS <small>(Insured Vehicle)</small>	Passengers in Insured Vehicle	NAME	ADDRESS AND CONTACT NUMBER	INJURY
	For which purpose were they carried?			
Are they employees?				
THIRD PARTY DETAILS <small>(Other Party)</small>	3 rd Party's Full Name		ID Number	
	Postal Address		Cell Phone Number	
	Physical Address		Home / Work Number	
	Insurer & Policy Number		E-mail Address	
	Vehicle Make & Model		Vehicle Registration	
	Vehicle Damage			
Property Damage <small>(Other than Insured Vehicles)</small>	NAME, ADDRESS & PHONE NO		DETAILS OF DAMAGE / INJURY	

WITNESS	Full Name		Phone Number		
	Address				
ACCIDENT DETAILS	<i>Circle the correct option</i>	BEFORE ACCIDENT		MOMENT OF IMPACT	
	Speed (kilometres per hour)	Km ph		Km ph	
	a) Weather conditions b) Visibility	a) Good / Fair / Poor b) Good / Fair / Poor		a) Good / Fair / Poor b) Good / Fair / Poor	
	a) Road surface b) Width of road	a) Tar / Gravel b) Single / Dual / Highway / One Way / Parking Lot		a) Tar / Gravel b) Single / Dual / Highway / One Way / Parking Lot	
	a) Vehicle lights on? b) Street lighting?	a) Yes / No b) Yes / No		a) Yes / No b) Yes / No	
	Any warning given by you?			Driver tested for Alcohol/Drugs?	
	Police Station and Contact Number			Case/Reference Number	
	Detailed Description of the accident				
SKETCH OF ACCIDENT (If necessary use separate page)					
<p><i>Please show clearly the point of impact and indicate the direction of travel by arrows. Give details of any road safety signs or warning signs in the vicinity of the scene of the accident.</i></p>					
<p>It is important that you notify the insurers immediately you become aware of any impending prosecution, inquest or demand. We hereby declare the foregoing particulars to be true in every respect.</p>					
Signature of Insured:			Date:		
Signature of Driver:			Date:		

Please attach the following supporting documentation:

- **A CLEAR ENLARGED SCAN OF THE DRIVERS LICENSE & ID – MUST BE LEGIBLE**
- **A QUOTATION FOR THE REPAIR**
- **ALL 3RD PARTY DETAILS**
- **CASE NUMBER**

Please send claim form and above documentation to:

PLEASE NOTE YOU ONLY HAVE 30 DAYS FROM DATE OF ACCIDENT TO GET ALL DOCUMENTATION TO THE INSURER