



MOTOR VEHICLE CLAIM FORM

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

Claim No:

Policy No:

Insurance Coy:

Due Date:

Branch:

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 the rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993.

1. POLICY HOLDER		INSURED VEHICLE	
Surname of Insured OR Name of Company:		MAKE:	
First Names of Insured:		MODEL:	
Address:		TYPE: (eg. Van, Car, Artic, Flat-top etc.)	
		YEAR:	REG NO:
Contact Telephone numbers: (Home) (Business)	Has the vehicle been modified in any way:		
Name of any other party with financial interest in the vehicle:	Is the vehicle as 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):	Date of Birth:...../...../.....	Driver licence and type:	
Address:	Telephone:	FULL <input type="checkbox"/> RESTRICTED <input type="checkbox"/> LEARNERS <input type="checkbox"/>	
	Home	Number Issue Date.....	
Occupation:	Bus.....	Classes	
Your relationship to Policyholder:	Employer.....	YEARS HELD.....	
1. Was the vehicle being driven with the owner's consent?	YES <input type="checkbox"/> NO <input type="checkbox"/>	IF "NO" PLEASE PROVIDE DETAIL	
2. Is he/she the main driver of the Insured vehicle?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. If not the Policyholder do you own a vehicle? (name of Insurance Co.)	YES <input type="checkbox"/> NO <input type="checkbox"/>	IF "NO" PLEASE PROVIDE DETAIL	
4. Did driver consume liquor and/or drugs (include. 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	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"/>	

