



# MOTOR CLAIM FORM

## INSURED INFORMATION

Name (First, Middle Name, Surname or Company) <sup>1</sup>		Date of Birth: dd/mm/yyyy <sup>2</sup>	
Address <sup>3</sup>		Contact Number <sup>4</sup>	
Occupation / Nature of Business <sup>5</sup>	Email <sup>6</sup>	VAT Registration Number <sup>7</sup>	BIR Number <sup>8</sup>

## VEHICLE INFORMATION

Registration Number <sup>9</sup>	Make & Model <sup>10</sup>	Year of Manufacture <sup>11</sup>	Total Number of Passengers at time of loss <sup>12</sup>
Policy Number <sup>13</sup>	Expiry Date: dd/mm/yyyy <sup>14</sup>	Sum Insured <sup>15</sup>	Mortgage or Hire Purchase applicable <sup>16</sup>

Please state exactly what the vehicle was being used for at the time of the accident<sup>17</sup>

Was the vehicle being used with the Owner's consent<sup>18</sup>?  YES  NO

### COMMERCIAL VEHICLES: CARRIAGE OF GOODS

Owner of Goods <sup>19</sup>	Nature of Goods <sup>20</sup>
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## DRIVER INFORMATION

Name (First, Middle Name, Surname) <sup>21</sup>	Relationship to Owner <sup>22</sup>	Contact Number <sup>23</sup>
Address <sup>24</sup>	Occupation / Nature of Business <sup>25</sup>	Email <sup>26</sup>

Date of Birth: dd/mm/yyyy <sup>27</sup>	Driver's Permit Number <sup>28</sup>	Class <sup>29</sup>	Date of Issue: dd/mm/yyyy <sup>30</sup>	Expiry Date: dd/mm/yyyy <sup>31</sup>
Taxi Badge Number <sup>32</sup>	Date of Issue: dd/mm/yyyy <sup>33</sup>	Expiry Date: dd/mm/yyyy <sup>34</sup>		

Has the driver had any previous accidents<sup>35</sup>?  YES  NO *(If yes, provide details)*

Does the driver own a vehicle<sup>36</sup>?  YES  NO *(If yes, state Registration No. & Insurer)*

Does the driver have any physical infirmity, defective vision or hearing, or loss of a limb or eye<sup>37</sup>?  YES  NO *(If yes, provide details)*

## ACCIDENT DETAILS

Date of Accident: dd/mm/yyyy <sup>38</sup>		Time <sup>39</sup> <input type="checkbox"/> AM <input type="checkbox"/> PM		Location <sup>40</sup>			
Was the road surface paved <sup>41</sup> ? <input type="checkbox"/> YES <input type="checkbox"/> NO		What was the condition of the road <sup>42</sup> ?					
In your opinion, who was at fault <sup>43</sup> ?				What was the weather condition like <sup>44</sup> ?			
Date Reported to Police: dd/mm/yyyy <sup>45</sup>		Police Station <sup>46</sup>		Name of Police Officer <sup>47</sup>		Police Officer's Badge Number <sup>48</sup>	
Did the police go to the scene <sup>49</sup> ? <input type="checkbox"/> YES <input type="checkbox"/> NO				Were measurements taken <sup>50</sup> ? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Was either party warned of prosecution <sup>51</sup> ? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(If yes, state which Party)</i>							
<b>INSURED'S VEHICLE<sup>52</sup></b>		<b>VEHICLE 1<sup>53</sup></b>		<b>VEHICLE 2<sup>54</sup></b>		<b>VEHICLE 3<sup>55</sup></b>	
Direction of travel		Direction of travel		Direction of travel		Direction of travel	
On which side of the road		On which side of the road		On which side of the road		On which side of the road	
Speed before accident	Speed after accident	Speed before accident	Speed after accident	Speed before accident	Speed after accident	Speed before accident	Speed after accident
Status of Lights <input type="checkbox"/> OFF <input type="checkbox"/> ON <input type="checkbox"/> DIM <input type="checkbox"/> BRIGHT		Status of Lights <input type="checkbox"/> OFF <input type="checkbox"/> ON <input type="checkbox"/> DIM <input type="checkbox"/> BRIGHT		Status of Lights <input type="checkbox"/> OFF <input type="checkbox"/> ON <input type="checkbox"/> DIM <input type="checkbox"/> BRIGHT		Status of Lights <input type="checkbox"/> OFF <input type="checkbox"/> ON <input type="checkbox"/> DIM <input type="checkbox"/> BRIGHT	
Was horn sounded? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was horn sounded? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was horn sounded? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was horn sounded? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Was indicator on? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was indicator on? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was indicator on? <input type="checkbox"/> YES <input type="checkbox"/> NO		Was indicator on? <input type="checkbox"/> YES <input type="checkbox"/> NO	

## DAMAGE TO YOUR VEHICLE

Please state damage <sup>56</sup>			Is the vehicle still in use <sup>57</sup> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Estimate for Repairs <sup>58</sup>		Where can the vehicle be inspected <sup>59</sup> ?		Name & Address of Repairer <sup>60</sup>

## PERSONAL INJURIES

<b>NAME 1<sup>61</sup></b>		<b>NAME 2<sup>62</sup></b>	
Address		Address	
Contact Number	Age	Contact Number	Age
Nature of Injury		Nature of Injury	

**PERSONAL INJURIES (Cont'd)**

Was this injured person treated in a Medical Institution? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(if yes, complete below)</i>		Was this injured person treated in a Medical Institution? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(if yes, complete below)</i>	
Where treated	Date treated: dd/mm/yyyy	Where treated	Date treated: dd/mm/yyyy
Details		Details	
Was this injured person: <input type="checkbox"/> An Occupant of your vehicle <input type="checkbox"/> A Cyclist <input type="checkbox"/> An Occupant of another vehicle <input type="checkbox"/> A Pedestrian		Was this injured person: <input type="checkbox"/> An Occupant of your vehicle <input type="checkbox"/> A Cyclist <input type="checkbox"/> An Occupant of another vehicle <input type="checkbox"/> A Pedestrian	

**THIRD PARTY VEHICLE INFORMATION**

VEHICLE 1 <sup>63</sup>	VEHICLE 2 <sup>64</sup>	VEHICLE 3 <sup>65</sup>
Registration Number	Registration Number	Registration Number
Make & Model	Make & Model	Make & Model
Third Party Insurer	Third Party Insurer	Third Party Insurer
Owner	Owner	Owner
Address	Address	Address
Contact Number	Contact Number	Contact Number
Name of Driver	Name of Driver	Name of Driver
Contact Number	Contact Number	Contact Number
Description of Damages	Description of Damages	Description of Damages

**DAMAGE TO OTHER PROPERTY DAMAGE**

Name of Owner <sup>66</sup>	Location of property / building <sup>67</sup>	Details of Damage <sup>68</sup>

**WITNESSES**

WITNESS 1 <sup>69</sup>	WITNESS 2 <sup>70</sup>	WITNESS 3 <sup>71</sup>
Address	Address	Address
Contact Number	Contact Number	Contact Number

