

MOTOR VEHICLE CLAIM FORM

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

INSURANCE COMPANY	<input type="text"/>	CLIENT NUMBER (if known)	<input type="text"/>
POLICY NUMBER	<input type="text"/>	C&G ROTHBURY CLAIM REFERENCE NUMBER	<input type="text"/>
Pursuant to the Privacy Act 1993 the following is brought to your attention:		EXCESS	<input type="text"/>
(a) This claim form collects personal information about you		(d) The collection of this information is required pursuant to the terms of your insurance policy	
(b) The information is collected to evaluate your claim		(e) The failure to provide this information may result in your claim being declined	
(c) The intended recipient of the information is:		(f) You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993	
<input type="text"/>			
herein after called ("the Company") and is being held by them at			
<input type="text"/>			

1. POLICY HOLDER

Surname of Insured or Name of Company	<input type="text"/>	INSURED VEHICLE	
First Name(s) of Insured	<input type="text"/>	Make	<input type="text"/>
Address	<input type="text"/>	Model & Type (e.g. Van, Car, Artic, Flat top, etc)	<input type="text"/>
Home Telephone	<input type="text"/>	Year	<input type="text"/>
Business Telephone	<input type="text"/>	Registration Number	<input type="text"/>
Mobile Telephone	<input type="text"/>	Has the vehicle been modified in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of any other party with financial interest in the vehicle:	<input type="text"/>	If yes, please give details:	<input type="text"/>
Is there any other insurance on the vehicle or accessories?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the vehicle a used import?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Has the vehicle a current Certificate of Fitness?	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. PERSON DRIVING OR IN CHARGE OF THE INSURED VEHICLE (to be completed even if parked)

Full Name: (Mr / Mrs / Miss / Ms)	<input type="text"/>	1. Was the vehicle being driven with the owner's consent?	<input type="checkbox"/> Yes <input type="checkbox"/> No - If 'no', please give details:
Date of birth	<input type="text"/>		<input type="text"/>
Address	<input type="text"/>	2. Is he/she the main driver of the Insured vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No - If 'no', please give details:
Home Telephone	<input type="text"/>		<input type="text"/>
Business Telephone	<input type="text"/>	3. If not the Policy Holder, do you own a vehicle?	<input type="checkbox"/> Yes - if 'yes', name of Insurance Co: <input type="checkbox"/> No
Occupation	<input type="text"/>		<input type="text"/>
Relationship to Policy Holder	<input type="text"/>	4. Did the driver consume liquor and/or drugs (including medication) within 24 hours prior to the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver Licence Number	<input type="text"/>	5. Did the Police attend?	<input type="checkbox"/> Yes - if 'yes', Police File No.: <input type="checkbox"/> No
Licence type: <input type="checkbox"/> Full <input type="checkbox"/> Restricted	Licence version <input type="text"/>		<input type="text"/>
Date and Country of Issue	<input type="text"/>	6. Was a breathalyser or blood test, or any other such test done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		7. During the past 5 years, have you:	
		(i) Been convicted of any offence other than parking?	<input type="checkbox"/> Yes - if 'yes', type and penalty: <input type="checkbox"/> No
			<input type="text"/>
		(ii) Had any other accident, loss of claim in connection with any motor vehicle?	<input type="checkbox"/> Yes - if 'yes', brief details of year/cost/insurance co: <input type="checkbox"/> No
			<input type="text"/>

3. DETAILS OF OTHER PERSONS

Passengers in your vehicle:

Name Telephone

Address

Name Telephone

Address

Independent witnesses

Name Telephone

Address

Name Telephone

Address

Drivers/Owners of other vehicles or property:

Driver Owner

Address

Make/model of vehicle

Registration Number Telephone number

Damage to vehicle

Insurance company

4. DETAILS OF LOSS OR ACCIDENT

Please continue on a separate sheet if necessary

Date Time am / pm (circle one)

Location (e.g. Street) Suburb or Town

Weather
 Rain Overcast Bright sun Clear night Fog

Road
 Sealed Metal Wet Dry

What speed limit was in force?
 50km/h 70km/h 100km/h Other, detail

What was your speed prior to braking? At impact?

Please state reason for journey

Describe in detail how the accident occurred

Do you consider the other driver responsible for the accident?
 Yes No Please give your reasons

5. DAMAGE TO INSURED VEHICLE

NB Do not proceed with repairs without the Company's authority

Describe damage

Where is your vehicle currently?

Name of repairer/panelbeater

Telephone

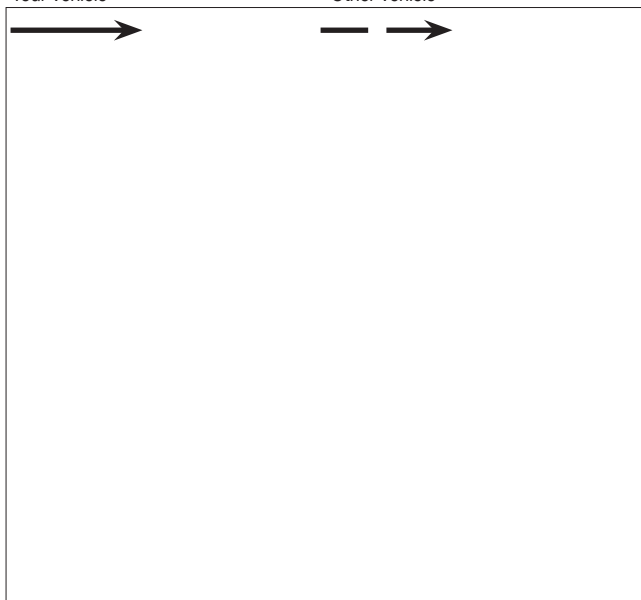
Have you obtained an estimate for repairs? Yes No

Amount of estimate obtained \$

6. SKETCH PLAN OF ACCIDENT

Please continue on a separate sheet, if necessary.

Indicate street names, direction of vehicles.

Your vehicle Other vehicle


7. DIRECT CREDIT AUTHORITY

If you would like any payment due to be paid direct to a bank account, please provide account details:

Name of Account

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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BANK BRANCH ACCOUNT NUMBER SUFFIX

8. DECLARATION

Note: Failure to provide full and truthful information could result in the Claim being declined.

- 1. I/We agree to the Company disclosing my/our personal information regarding this claim to: other parties including other members of the Insurance Industry and the database of the Insurance Claims Register (ICR Ltd), PO Box 474, Wellington, Where it will be retained and made available to other insurance companies to inspect.
(a) parties who have a financial interest in the subject matter of the policy and parties repairing or replacing the subject matter of the claim.
(c) I/We understand that I am/we are entitled to have certain rights of access to and correction of the personal information held by the Company and ICR Ltd.
2. I/We agree to the Company obtaining personal information about me/us that is, in the Company's view, relevant to this claim.
(a) from any other party including other members of the Insurance Industry and from Insurance Claims Register Ltd (ICR Ltd) which holds details of claims made by me/us under the policies with other insurers.

Policyholder's signature (if company, state capacity) Date

Driver's signature Date