

# MOTOR VEHICLE ACCIDENT / LOSS REPORT

THIS ORIGINAL COMPLETED FORM MUST BE GIVEN TO YOUR INSURER TOGETHER  
WITH AN ESTIMATE FOR THE COST OF REPAIRS TO YOUR VEHICLE

AGENCY \_\_\_\_\_ CLAIM NO.: \_\_\_\_\_  
POLICY NO. \_\_\_\_\_ APPLICABLE EXCESS \_\_\_\_\_

**THE INSURED**

NAME \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
BUS. ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
RES. ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
IS THE INSURED VAT REGISTERED? Yes  No  VAT REG. NO. \_\_\_\_\_

**PARTICULARS OF INSURED VEHICLE**

MAKE AND MODEL	CHASSIS NO.	ENGINE NO.	REGISTRATION NO.	SUM INSURED
_____	_____	_____	_____	_____

Is the vehicle subject to a Hire Purchase Agreement  Bill of Sale  Mortgage  Other?   
If so, state name and address of finance Company \_\_\_\_\_  
IS ANY ANTI-THEFT DEVICE FITTED TO THE VEHICLE? No  Yes  MAKE \_\_\_\_\_

**THE DRIVER**

NAME OF DRIVER \_\_\_\_\_ SEX Male  Female   
RELATIONSHIP TO INSURED \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
BUS. ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
RES. ADDRESS \_\_\_\_\_ PHONE NO. \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_  
DRIVER'S PERMIT NO. \_\_\_\_\_ ISSUE DATE \_\_\_\_\_ EXPIRY DATE \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ CLASS OF VEHICLE LICENSED TO DRIVE \_\_\_\_\_  
Has driver any physical impairment? \_\_\_\_\_  
For what purpose was vehicle used? \_\_\_\_\_  
Has driver been involved in any accident within the past three years? Yes  No   
Date \_\_\_\_\_ Vehicle No. \_\_\_\_\_ Ins. Co. \_\_\_\_\_  
Is the driver insured in his own name in respect of any other motor vehicle? Yes  No  If  
yes, state particulars of Ins. Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

**THE ACCIDENT**

DATE OF ACCIDENT \_\_\_\_\_ TIME \_\_\_\_\_  A.M.  P.M.  
LOCATION \_\_\_\_\_  
DIRECTION OF INSURED'S VEHICLE \_\_\_\_\_ DIRECTION OF OTHER CAR \_\_\_\_\_ SPEED \_\_\_\_\_  
ROAD SURFACE CONDITION Wet  Dry  WEATHER CONDITION Rainy  Sunny   
TO WHICH POLICE STATION WAS THE ACCIDENT/LOSS REPORTED? \_\_\_\_\_  
POLICE OFFICER'S NAME, NO. & RANK? \_\_\_\_\_  
WAS ANTI-THEFT DEVICE IN OPERATION AT THE TIME OF THE LOSS? Yes  No

**DAMAGE TO YOUR OWN VEHICLE**

Details of Damage \_\_\_\_\_  
  
If vehicle cannot be driven, where is it located? \_\_\_\_\_

**OCCUPANT(S) OF INSURED'S VEHICLE**

NAME(S)	RESIDENTIAL/BUSINESS ADDRESS	PHONE NO.
1) _____	_____	_____
2) _____	_____	_____

**OCCUPANT(S) OF OTHER VEHICLE**

NAME(S)	RESIDENTIAL/BUSINESS ADDRESS	PHONE NO.
1) _____	_____	_____
2) _____	_____	_____

**WITNESSES**

1) \_\_\_\_\_  
2) \_\_\_\_\_

**THIRD PARTY PROPERTY DAMAGE**

OWNER NAME(S) RESIDENTIAL/BUSINESS ADDRESS PHONE NO.

1) \_\_\_\_\_

2) \_\_\_\_\_

DRIVER NAME(S) RESIDENTIAL/BUSINESS ADDRESS PHONE NO.

1) \_\_\_\_\_

DATE OF BIRTH mm/dd/yy OCCUPATION DRIVER'S PERMIT NO. ISSUE DATE mm/dd/yy EXP. DATE mm/dd/yy

2) \_\_\_\_\_

DATE OF BIRTH mm/dd/yy OCCUPATION DRIVER'S PERMIT NO. ISSUE DATE mm/dd/yy EXP. DATE mm/dd/yy

MAKE & MODEL OF VEHICLE REGISTRATION NO. T/PARTY INSURER COVERAGE/POLICY NO.

1) \_\_\_\_\_

2) \_\_\_\_\_

EXTENT OF DAMAGE

1) \_\_\_\_\_

2) \_\_\_\_\_

**THIRD PARTY BODILY INJURY**

NAME AGE RES. ADDRESS PHONE NO.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

OCCUPATION EMPLOYER BUS. ADDRESS PHONE NO.

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

NATURE & EXTENT OF INJURIES ATTENDING PHYSICIAN AND/OR HOSPITAL

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

**SKETCH**

SHOW DIRECTIONS AND POSITIONS OF VEHICLES INVOLVED, DESIGNATING CLEARLY POINT OF CONTACT

**DESCRIPTION OF ACCIDENT**

In your opinion who was at fault? \_\_\_\_\_ Did such person admit responsibility? \_\_\_\_\_

\*\* Please do not exceed more than 250 words.

I/We declare that the above particulars are true and correct to the best of my/our knowledge and belief.

Date of Report \_\_\_\_\_ Signature of Driver \_\_\_\_\_

Signature of Insured \_\_\_\_\_

**PLEASE DO NOT DISCUSS THIS OCCURRENCE WITH ANYONE EXCEPT YOUR MOTOR INSURANCE REPRESENTATIVE**