



# Motor Vehicle Claim (Non Theft)

The issue of this form does not constitute an admission of liability on the part of the insurer.

Policy Number

Claim Number

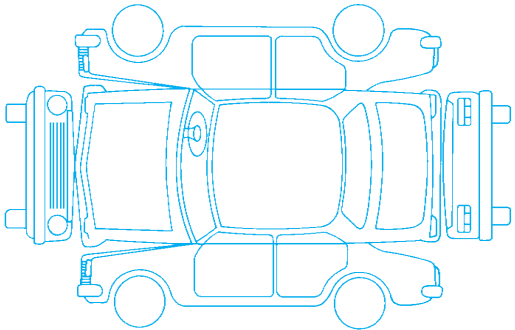
**Please complete all sections. Important: Attach one quotation from repairer.**

The Insured			
Full Name (Block Letters)	Surname	Given Name(s)	
Postal Address	State		Postcode
Are you registered for GST?	No <input type="checkbox"/> Yes <input type="checkbox"/>	What is your ABN?	<input type="text"/>
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?		
	No <input type="checkbox"/> Yes <input type="checkbox"/> – Specify amount claimed		% <input type="text"/>
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?		
	No <input type="checkbox"/> Yes <input type="checkbox"/> – Specify amount claimed		% <input type="text"/>
Contact Numbers	Business	( )	Private ( )
	Facsimile	( )	Mobile

Vehicle Details			
Make of Vehicle	Year	/ /	Registered No.
Model	Colour		Odometer Reading
Registered Owner			
Address	State		Postcode
Do you owe money on your vehicle?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
Name of Lender	Account Number		
Address	State		Postcode

Driver Details			
Full Name (Block Letters)	Surname	Given Name(s)	
Address	State		Postcode
Contact Numbers	Business	( )	Private ( )
	Facsimile	( )	Mobile
Relationship to Insured			
Licence Number	Expiry Date	/ /	Date of Birth / /
How long has the driver been licensed for this type of vehicle?	years		
Did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
Did the driver undergo a breath test, breath analysis or blood test?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
What was the reading?	(Please attach copy of the certificate.)		

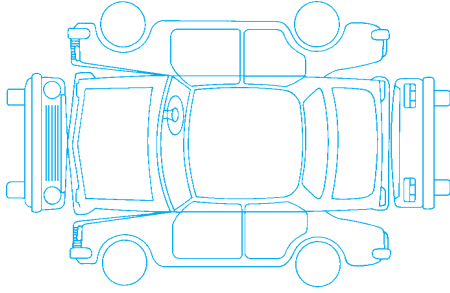
Incident Details					
Date	/ /	Day		Time	am/pm
Where did the incident happen?					
Street		Suburb		Nearest Cross Street	
Road surface: Dry <input type="checkbox"/> Wet <input type="checkbox"/> Loose <input type="checkbox"/>					
At the time of the accident the insured vehicle was: Parked <input type="checkbox"/> Stationary <input type="checkbox"/> Moving <input type="checkbox"/> Speed					
Traffic controls: None <input type="checkbox"/> Stop sign <input type="checkbox"/> Traffic Lights <input type="checkbox"/> Roundabout <input type="checkbox"/> Give way sign <input type="checkbox"/> Other <input type="checkbox"/>					
Number of other vehicles involved					
If applicable, what type of goods were being transported at time of loss?					
What happened?					
Who was at fault?	Surname		Given Name(s)		
<b>SKETCH DIAGRAM OF ACCIDENT</b>					
<p>1. Name streets</p> <p>2. Indicate direction of travel</p> <p>3. Your vehicle <input checked="" type="checkbox"/></p> <p>4. Other vehicle <input type="checkbox"/></p>					

Damage to Your Vehicle			
Are you claiming for the damage to your vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Was the vehicle towed? No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details			
Name of tow company			
Where was it towed?		Distance towed	Kms
Where is vehicle now?			
<b>SKETCH DIAGRAM</b>			
<p>Shade in damage to vehicle.</p> <p>Indicate point of impact ( X )</p>			
			

Owner of Other Vehicle			
Name		Surname	
		Given Name(s)	
Address			
		State	Postcode
Contact Numbers	Business	( )	Private ( )
Insurance Co.		Policy No.	

Driver of Other Vehicle					
Name	Surname		Given Name(s)		
Address					
				State	
Contact Numbers	Business	( )	Private	( )	
Date of Birth	/	/	Driver's Licence Number		
Was the owner in the vehicle at the time of the accident?					No <input type="checkbox"/> Yes <input type="checkbox"/>
<b>IF THERE IS MORE THAN 1 OTHER VEHICLE INVOLVED PLEASE ATTACH DETAILS.</b>					

Other Vehicle					
Registration No.		Year of Manufacture		Make of vehicle	
Model				Colour	

Damage to Other Vehicle	
<b>SKETCH DIAGRAM</b>  Shade in damage to vehicle.  Indicate point of impact ( X )	

Other Parties					
Give details of pedestrians, owners of property or owners of animals involved.					
Name	Surname		Given Name(s)		
Address					
				State	

Police					
Did a Police Officer attend the accident scene, No <input type="checkbox"/> Yes <input type="checkbox"/> or did you report the incident to the police? No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details					
Name				Rank	
Station					
Date of report	/	/	<i>(Please attach a copy of the Police Report.)</i>		
Name of person to be charged or cautioned					
Nature of charge or caution					

Witness(es) Details					
Name	Surname		Given Name(s)		
Address					
				State	
Contact Numbers	Business	( )	Private	( )	
Was this witness in the insured vehicle?					No <input type="checkbox"/> Yes <input type="checkbox"/>
Name	Surname		Given Name(s)		
Address					
				State	
Contact Numbers	Business	( )	Private	( )	
Was this witness in the insured vehicle?					No <input type="checkbox"/> Yes <input type="checkbox"/>

