

## Motor Claim Form

Important Note - Please ensure Your Claim Form is completed in full and returned within 7 days after receipt. Failure to complete your form in full will result in the form being returned to you and will hold up the processing of your claim.

**Insured Person**

**Driver**

Policy no.: _____ Name of Insured: _____ Name of Beneficiary: _____ Address: _____ Contact Phone no.: _____	Name of Driver: _____ Address: _____ E-Mail: _____ Driving License #: _____ Valid Until: _____
---	--

**Insured Accident Information**

**Insured's Vehicle**

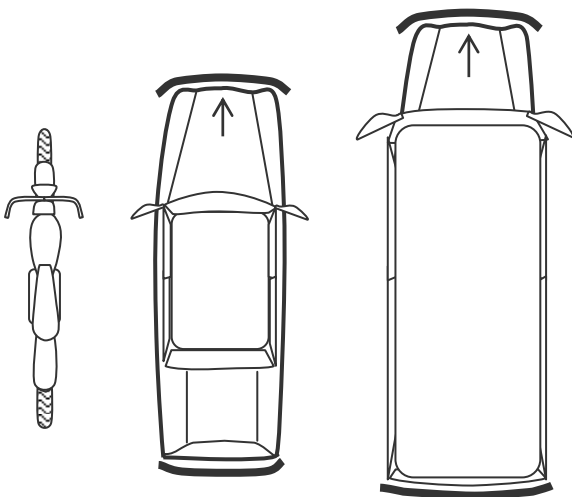
Date: _____ Time: _____ Location: _____	Brand: _____ Model: _____ License Plate #: _____ Engine #: _____
---	---

Bodily Injury:       Yes       No

Vehicle Damage:     Yes       No

**Accident Drawing**

**Show the first impact location with an arrow (↑)**



**Detail of Third Party**

Name:	Age	Phone contact:
Brand of Vehicle:	Address:	
Name of Insurance:	Model:	
Type of Insurance:	Plate no.:	

## Declaration

A - Accident circumstances	
B - Was there a police report? If Yes, please attach a copy.	<input type="checkbox"/> Yes <input type="checkbox"/> No
C - Driver of Insured vehicle: Is he the usual driver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is he an employee of the Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If not, reason why he was driving?	
Purpose of traveling:	
D - Insured vehicle: Usual parking location	
If the vehicle - had been rented, name and address of the company:	
- was it linked with another vehicle (towing or towed) at accident occurrence, indicate plate number of that vehicle :	
E - Material damage (other than to third party vehicle described above) kind and importance:	
Name and address of the owner:	
F - Injured persons: Name, sex, age, position and address:	
Is he insured's employee?	
Type and severity of bodily injury:	
Location at accident's occurrence (driver, front or back passenger from insured or third party vehicle, bikes,      pedestrian.):	
Did he wear a helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fasten his belt?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospitalization location:	
First emergency care location:	
<b><u>Official Stamp:</u></b>     Date:	I (We) confirm and certify that the above details are true and correct.  <b><u>Driver's Signature:</u></b>   Date: