

General Claim Form



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

Policy Number	
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Claim Number	
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Please complete all sections. Important: Attach one quotation from repairer.

Insured Details									
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?						
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			%		
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			%		
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)	

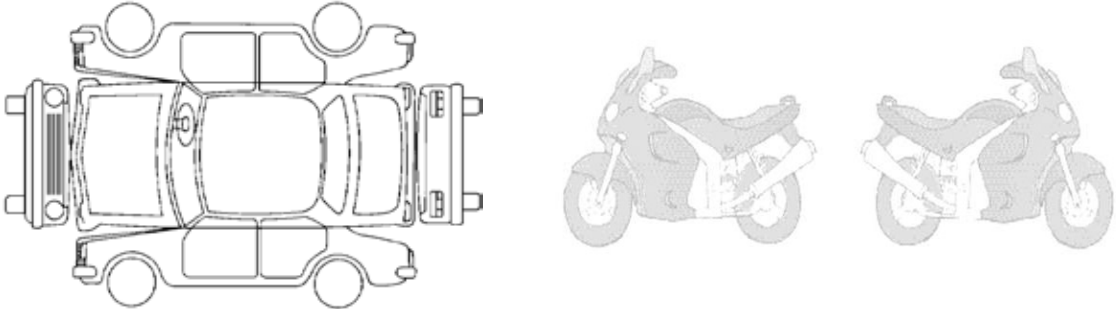
SKETCH DIAGRAM OF ACCIDENT

<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>	
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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?		

SKETCH DIAGRAM

<p>Shade in damage to vehicle.</p> <p>Indicate point of impact (X)</p>	
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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	Postcode
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"/>
IF THERE IS MORE THAN 1 OTHER VEHICLE INVOLVED PLEASE ATTACH DETAILS.					

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

Damage to Other Vehicle	
Details of damage to other vehicle	

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

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	/ /	Police Report #	
Name of person to be charged or cautioned			
Nature of charge or caution			

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

