



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

Pursuant to the Privacy Act 1993 the following is brought to your attention:

- (a) This claim form collects personal information about you;
- (b) The information is collected to evaluate your claim;
- (c) The intended recipient of the information is: The Insurer named below (hereinafter called "the Company") and is being held by them at their head office
- (d) The collection of this information is required pursuant to the terms of your insurance policy;
- (e) The failure to provide this information may result in your claim being declined;
- (f) You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993.

Claim No : Policy No :
 Insurance Coy : Due Date :
 Branch : Excess : Premium Paid : Y / N

1. POLICYHOLDER	INSURED VEHICLE
Surname of Insured: OR Name of Company:	MAKE:
First Names of Insured:	MODEL:
Address:	TYPE: (eg. Van, Car, Artic, Flat-top etc.)
Contact Telephone numbers: (Home) (Business)	YEAR: REG NO:
Name of any other party with financial interest in the vehicle:	Has the vehicle been modified in any way:
Is there any other insurance on the vehicle or accessories: YES <input type="checkbox"/> NO <input type="checkbox"/>	Is the vehicle a used import: YES <input type="checkbox"/> NO <input type="checkbox"/>
	Has the vehicle a current Certificate of Fitness: YES <input type="checkbox"/> NO <input type="checkbox"/>
2. PERSON DRIVING OR IN CHARGE OF THE INSURED VEHICLE (to be completed, even if parked)	
Full Name (Mr/Mrs/Miss/Ms):	Address:
Date of Birth / /	Occupation:
Telephone No.: H: B:	Relationship to policyholder:
Driver Licence No.: Type: Years Held:	Date & Country of Issue:
Licence Classes: (Please List)	Licence Special Conditions: (Please List)
1. Was the vehicle being driven with the owner's consent?	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "NO" PLEASE PROVIDE DETAIL
2. Is he/she the main driver of the Insured vehicle?	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
3. If not the Policyholder do you own a vehicle? (name of insurance co)	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
4. Did driver consume liquor and/or drugs (includ. medication) within 24 hours prior to the accident?	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
5. Did the Police attend?	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
6. Was a breathalyser, or blood test, or any other such test done?	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
7. During the past 5 years, have you:	
(i) Been convicted of any offence other than parking (type and penalty)	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL
(ii) Had any other accident, loss of claim in connection with any motor vehicle (brief details of year/cost/insurance coy)	YES <input type="checkbox"/> NO <input type="checkbox"/> IF "YES" PLEASE PROVIDE DETAIL

3. DETAILS OF OTHER PERSONS

Passengers in your vehicle	Independent Witnesses
Name	Name
Address	Address
Telephone	Telephone
Name	Name
Address	Address
Telephone	Telephone
Driver/Owner of other vehicle or property	
Name	Name
Address	Address
Telephone Insurance Coy	Telephone Insurance Coy
Details of vehicle/property	Details of vehicle/property
Registration Number	Registration Number

4. DETAILS OF LOSS OR ACCIDENT (Please continue on a separate sheet, if necessary)

Date Time am/pm (delete one)

Location (eg. Street) Suburb or Town

Weather: Rain Overcast Fog Bright Sun Clear Night

Road: Sealed Metal Wet Dry

What speed limit was in force? 50 Km/hour 100 Km/hour Other

What was your speed: Prior to braking At impact

Please state reason for journey

Describe in detail how the accident occurred

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What, in your opinion, caused the accident

5. DAMAGE TO INSURED VEHICLE (NB: Do not proceed with repairs without the Company's authority)

Describe damage

Repairer Telephone Estimate \$

If not at above, Date of repair OR where can vehicle be inspected

6. SKETCH PLAN OF ACCIDENT (Please continue on a separate sheet, if necessary)

Indicate: Street names; direction of vehicles. Your vehicle  Other vehicle 

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

- 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 data base of the Insurance Claims Register (ICR Ltd) P.O. Box 474, Wellington, where it will be retained and made available to other insurance companies to inspect.
 - Parties who have a financial interest in the subject matter of the policy and parties repairing or replacing the subject matter of the claim.
 - 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.
- I/We agree to The Company obtaining personal information about me/us that is, in The Company's view, relevant to this claim.**
 - 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 policies with other insurers.

All the information and answers (whether written or oral) given to The Company in connection with this claim are correct and that no information relevant to the claim has been omitted. I/We authorise The Company to act on my/our behalf.

Policyholder's signature (If a company, state capacity) Date

Driver's signature Date