

Motor Vehicle Claim Form



It is essential that this form be returned directly to Ansvar Insurance, with all questions answered, at the earliest opportunity. Please print your answers and where appropriate.

Office use only Claim number

1. Policyholder details

Name/Business name	Policy number						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address						State	Postcode
<input type="text"/>						<input type="text"/>	<input type="text"/>
Telephone: Home	Telephone: Work	Telephone: Mobile		Fax number			
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>			
Email	Occupation						
<input type="text"/>	<input type="text"/>						

2. Insured Vehicle

Registration number	Year of manufacture	Make	Model
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Body type (eg. Sedan)	Odometer reading	Expiry date of registration	
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Has the vehicle been modified or fitted with accessories or optional extras other than those supplied at the maker's option?

Yes No *If yes, describe the modifications/accessories*

Was there any unrepaired damage to the vehicle before the incident? Yes No *If yes, please provide details*

When was the vehicle purchased? / / Amount Paid \$

Is the vehicle under finance? Yes No *Name of finance company*

Amount outstanding \$

For what purpose was the vehicle being used at the time of the collision? eg. private use only, carrying goods in connection with business etc?

Was any other insurance (other than Compulsory Third Party Insurance) in force on the vehicle at the time of the collision?

3. Person in charge of vehicle at time of loss

Name	Date of birth
<input type="text"/>	<input type="text"/>
Address	Telephone number
<input type="text"/>	<input type="text"/>

Victoria AD GPO Box 1655 Melbourne 3001 FX +61 3 9614 1545	New South Wales AD PO Box 1410 Parramatta 2124 FX +61 2 9687 9564	Queensland AD GPO Box 747 Brisbane 4001 FX +61 7 3011 8999	South Australia AD PO Box 630 Fullarton 5063 FX +61 8 8338 1920	Western Australia AD PO Box 840 West Perth 6872 FX +61 8 9324 2013	Tasmania AD PO Box 330 Launceston 7250 FX +61 3 9614 1545
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Licence No. of driver. Please include photocopy of drivers licence

Date issued

Expiry date

How long has driver been licenced in Australia? Years

Date first licence obtained

In the past 5 years has the driver or insured ever had a policy of insurance cancelled or declined or an excess imposed or increased?

Yes No *If yes, please give details*

Has driver been convicted of an offence in connection with a motor vehicle, in the past 5 years? Yes No *If yes, please give details*

Has driver had licence suspended or cancelled in the past 5 years? Yes No *If yes, please give details*

If driver is not Policyholder, driver's percentage of this vehicle's usage %

Had driver consumed any medication, drugs or alcohol that day? Yes No

If yes, how long before the accident?

State the type of medication, drugs or alcohol

Quantity consumed

Relationship to the owner, are you: a. the owner; b. an employee; c. a relation or friend of owner.

In the past 5 years has the driver or insured had a loss/accident in respect to a motor vehicle? *Give dates and details and name of Insurer involved*

4. The collision

Day

Date

Time

When did the collision happen?

Where did the accident happen?

What were the road conditions at the time of the collision? Sealed roadway

Wet

Dry

Unsealed roadway

Wet

Dry

What were the weather conditions at the time of the collision? Fine

Overcast

Raining

Storm

Hail

Or other weather condition

At the time of the collision what was the approximate speed of:

a. Your vehicle before impact?

b. Other vehicle before impact?

Did either driver admit fault?

Yes

No

If yes, your driver?

Other driver?

How did the collision happen? Describe in detail the circumstances leading up to the collision and how it happened. It is important to be as accurate as you can. Do not hide any facts or circumstances which may not be in your favour. Please print clearly.

Details of property Description of property (eg. building, fence, etc.)

Owner's name

Address

State

Postcode

Was there any damage to the other vehicle or property as a result of the collision? Yes No *If yes, complete below*

Description of damage to other vehicle or property

If any communication is received by you, please forward it immediately to this office

7. Witnesses

Were there any witnesses to the collision? Yes No *If yes, state the witness particulars*

Name of witness No.1

Address

State

Postcode

Telephone: Home

Telephone: Work

Telephone: Mobile

Type of witness Passenger in your vehicle Passenger in other vehicle Independent eye witness

Name of witness No.2

Address

State

Postcode

Telephone: Home

Telephone: Work

Telephone: Mobile

Type of witness Passenger in your vehicle Passenger in other vehicle Independent eye witness

8. Police Please attach the police report to this claim form

Were the police advised of the collision? Yes No *If yes, did the police attend the accident* Yes No

or the accident was reported to police station at

on

And in both cases state the Officer's name

and number

Police Report Number

Was either driver charged with an offence?

 Yes No

If yes, indicate if: your driver and the offence

If yes, indicate if: other driver driver and the offence

Was either driver asked to take a blood/breathalyser test? Yes No *If yes, attach copy of results of test of your driver*

9. Goods and services tax To ensure you do not incur any unnecessary GST liabilities on this claim complete these details

Are you registered for GST purposes? Yes No

What is your ABN?

If you have registered and have an ABN, have you claimed or will you be claiming an input tax credit on the GST applicable to this policy? Yes No

Is the amount claimed less than 100% of the GST applicable to the premium? Yes No

Specify the percentage amount claimed

 %

10. Electronic Funds Transfer Settlement of your claim may involve a cash settlement. Please complete the following if you are interested in an EFT Payment

Account name

BSB number

Account number

11. I declare that all the information I have given is true and correct

Signature

Date

Ansvar Insurance is a member of the insurance industry's impartial Financial Ombudsman Service (FOS). This independent service is provided to the insuring public at no cost and aims to resolve claims complaints quickly and informally. In the unlikely event of a complaint arising, you should firstly contact the local Ansvor Insurance Regional Manager. In most cases the problem will be resolved easily. If you are not satisfied with the response given by the Regional Manager you may contact our Internal Dispute Resolution Committee for advice and assistance in resolving your claim.

Privacy The information we collect assists us to make a decision on whether we will accept your claim. If you do not provide this information we may be unable to process your claim. We may use third party suppliers (agents, loss adjusters, assessors and mailing houses) to carry out specialised activities on your behalf. These organisations are aware of their obligations under Privacy provisions. At any time you may request access to your personal information and correct it if it is wrong. We value the personal information you give to us and we will take all reasonable precautions to prevent unauthorised access to this information.