Commercial Motor Vehicle Claim Form

1. Policy Details

Policy Number(s)

Expiry Date

2. Client Details

Insured's Name

Address

Suburb:	State:	Post Code:

Contact Information

Mobile:	Work:	Home:
Email:		

Goods and Services Tax – to ensure you do not incur any unnecessary GST liabilities on this claim please advise your
(a) ABN

(b) Entitlement to an Input Tax Credit in respect of:
(i) Insurance Premium _______% and (ii) the property which is the subject of this claim _______%

3. Particulars of the motor vehicle(s)

Year:	Make:	Model:
Body Type:	Colour:	
Registration:		Registration Expiry:
Vehicle ID (VIN/Chassis):		
Engine Number:		
Date Purchased:		Price Paid:
CTP Insurer:	Name of Owner:	
Name of Finance Co/Bank if vehicle encumbered:		
Type and Weight of Load Being Carried (if applicable):		

4. Particulars of Trailer 1 (if applicable)

Year:	Make:	Model:
Body Type:	Colour:	
Registration:		Registration Expiry:
Vehicle ID (VIN/Chassis):		
Engine Number:		
Date Purchased:		Price Paid:
CTP Insurer:	Name of Owner:	
Name of Finance Co/Bank if vehicle encumbered:		
Type and Weight of Load Being Carried (if applicable):		

5. Particulars of Trailer 2 (if applicable)

Year:	Make:	Model:
Body Type:	Colour:	
Registration:		Registration Expiry:
Vehicle ID (VIN/Chassis):		
Engine Number:		
Date Purchased:		Price Paid:
CTP Insurer:	Name of Owner:	
Name of Finance Co/Bank if vehicle encumbered:		
Type and Weight of Load Being Carried (if applicable):		

6. Driver or Person in Charge of Vehicle

Surname:	Given Names:	
Address:	State:	Post Code:
Phone:	Mobile:	
Date of Birth:	Age:	
Drivers Licence No.:	Class:	
State of Issue:	Expiry Date:	
How long has this driver been licenced to operate THIS CLASS of vehicle?:		
Relationship of Driver to Insured (eg. Employee, sub contractor etc.):		
Was vehicle driven with Insured's consent: YES ☐ NO ☐ If NO, please supply details:		
Was any intoxicating liquor or drugs (including prescription drugs) consumed in the 12 hours preceding the accident? YES ☐ NO ☐ If YES, please supply details:		
Did the driver undergo a breathalyser or blood test? Breathalyser YES ☐ NO ☐ Blood Test YES ☐ NO ☐ If YES, what were the test results?		

*Photocopies of both sides of licence and log books (where applicable) must be attached

7. History

Details of Owner(s) history – past 5 years
Traffic and/or criminal offences?
Licence suspensions/cancellations?
Refusal and/or cancellation of any motor vehicle policy by an insurer?
Prior accidents or losses relative to any motor vehicle?

8. Details of Accident (to be completed by Driver)

Date (mm/dd/yyyy):	Time: am / pm
Exact Location:	
Approx Speed of your vehicle: km/hour	Approx Speed of other vehicle: km/hour
Journey Commenced: Time:	Place:
Vehicle Destination:	Inbound or Outbound to Home Base?
Weather and Road Conditions:	
Describe in Detail how the accident occurred:	

In the Driver's opinion, who was responsible for the accident	
Name:	Why?
Has any claim been made against you? YES ☐ NO ☐ If YES, please provide details	
Reported to Police? YES ☐ NO ☐ If YES, Date (dd/mm/yyyy) and Time am/pm reported to police Did Police attend the scene? YES ☐ NO ☐ Name and station of police officer who took accident Particulars: Is police action pending? YES ☐ NO ☐	

9. Independent Witnesses

Name:		
Phone Number:		
Address:	State:	Post Code:

10. Persons Injured in the Accident

Name:		
Phone Number:		
Address:	State:	Post Code:

11. Damage to Insured Vehicle

Give brief details of loss or damage to your vehicle:
Has a repair quotation been obtained? YES ☐ NO ☐ If YES, please attach quote Where can vehicle be inspected?____________________ Was your vehicle damaged? YES ☐ NO ☐ If tyres damaged, approximate mileage ____________ Was your vehicle towed away? YES ☐ NO ☒ If YES name of company:____________________ Have you obtained 2 repair quotes? YES ☐ NO ☐, lowest quote:____________ Please attach copies of ALL quotes Who is your preferred repairer?____________, Phone Number:____________ Is the vehicle there? YES ☐ NO ☐ If no, where is the vehicle located?

12. Other Persons Involved in this Accident (or the owner of the other vehicle)

Drivers Name:	Licence Number:	
Phone Number:		
Address:	State:	Post Code:
Vehicle Details Make: Registration Number: Owner of Vehicle (if different to driver):	Model:	
Loss/Damage to Vehicle:		

13. Diagram of Accident
(to be completed providing street named traffic lights, give way signs etc.)
Indicate your own vehicle as A
Indicate any other vehicles as B

14. Declaration

I/We solemnly and sincerely declare:

1. That the information supplied on this Claim Form and Statement of Claim is true in every respect
2. I/We understand that the claim may be refused if information is withheld, false, misleading or concealed.
3. That there was no other insurance covering this loss current at the date of this incident
4. I/We acknowledge that this Claim Form is a Legal Document and as such may be used in any legal proceedings resulting from this claim.

Signature of Driver

Date (dd/mm/yyyy)

Signature of Insured(s)

Date (dd/mm/yyyy)

EFT Details for Settlement

Bank:
Account Name:
BSB:
Account Number: