Associated Insurance Brokers Cape

Associated Insurance Brokers Cape 2006 (Pty) Ltd
Reg No 2005/026692/07 Licensed financial services provider (No 31032)

PO Box 5855, TygerValley 7536
Tel: 0861 242 123
Fax: 086 520 0920
email: claims@aib.co.za

# CLAIM FORM: MOTOR ACCIDENT

Reset Submit

| QUESTIONS | ANSWERS |
|---|---|
| **Insured** | |
| Policy Number | |
| Name of Insured | |
| Identity Number | |
| Occupation of Insured | |
| Address | |
| Tel. No. | Home: Work: Cell: |
| **Vehicle** | |
| Make | |
| Model | |
| Year | |
| Registration | |
| Kilometers completed | |
| Date of Purchase and price paid | |
| **Damage** | |
| Describe damage to own Vehicle | |
| Is the Vehicle drivable | YES NO |
| Indicate your preferred geographical area where your repairs can be seen to | |
| **Driver** | |
| Full Name | |
| Address | |
| Occupation | |
| Identity No. | |
| Drivers License | No Date Place Code |
| State fully the purpose for which the vehicle was used. | |
| Was he / she driving with your permission? | YES NO |
| Was he / she driving in your employ? | YES NO |
| Is he / she owner of another vehicle? | YES NO |
| If yes, give name of insurer and policy number | |
| Details of any convictions for motoring offences | |
| Has license ever been endorsed? | YES NO |
| Has he / she any physical defects? | YES NO |
| Details of previous accidents | |

**Passengers [Insured Vehicle]**

Passengers in Insured Vehicle

| Name | Address | Injury |
|---|---|---|
| | | |
| | | |
| | | |

For what purpose were they carried?

Are they employees? YES NO

**Other Party**

Other Vehicles

| Reg. No. | Make | Name & Address of owner | Details of Damage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Personal injuries (other than in Insured vehicle)

| Name of insured | Relationship to accident eg driver \| passenger | Details of injuries | Name of hospital if applicable |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

(continue on page 2)

# MOTOR ACCIDENT CLAIM FORM

QUESTIONS | ANSWERS

## Other Party

| Property other than vehicles | Name & Address of owner | Details of damage |
|---|---|---|
| | | |
| | | |
| | | |

## Witnesses

| | |
|---|---|
| Name, address and phone no. | |
| Name, address and phone no. | |

## Accident

| | | |
|---|---|---|
| Date, time and place | | |
| Speed | Before Accident | Moment of Impact |
| Weather Conditions | | |
| Visibility | | |
| Road Surface Type | | |
| Width of Road | | |
| Were vehicle lights on? If yes which lights? | YES | NO |
| Street lighting | | |
| Was any warning given to you eg. Hooter, indicator etc? | YES | NO |
| Name of Police / Traffic Officer who recorded accident | | |
| Police Station and Reference No. | | |
| Was driver tested for alcohol or drugs? | YES | NO |

**Description of accident**

**Sketch of accident**

## License Inspected

I have inspected the driver's license and it is free of endorsements as shown.
(Please attach a copy of drivers license and page 1- of the driver's identity document)

Capacity:

Signature

## Authority of payment INSURED'S BANKING DETAILS

It is recommended that if any amount is payable directly to you, it be transmitted by Electronic Bank Transfer for speedier settlement and security reasons. If you are agreeable to this, please complete and provide the following information

| | |
|---|---|
| Name of Bank | |
| Account No. | |
| Account Type | |
| Branch & Code No. | |
| Name of account Holder | |

## Declaration

I / We hereby declare that the above and foregoing particulars to be true in every aspect

Signature of Driver

Date:

Signature of Insured

Capacity:

Date:

N.B. 1 - It is important that you notify the insurers immediately you become aware of any impending prosecution, inquest or demand.
N.B. 2 - Any personal injuries noted overleaf must be reported separately to the multilateral motor vehicle accident fund without delay.