1st Floor, # 2 Bridge Street, P.O. Box 1860, Castries, Saint Lucia
Tel: 1 (758) 451-3244 Fax 1 (758) 458-1222

MOTOR CLAIM FORM

Notification ☐ **Claim** ☐	**Claim No:**
	Name of Agent/Broker:

A. PARTICULARS OF INSURED

Name of Insured:	
Home Address:	Telephone No:
Business Address:	Telephone No:
Occupation:	E-Mail address:

B. PARTICULARS OF INSURANCE

Policy No.:	Type of Cover:	Excess:	Insured Value:

C. PARTICULARS OF VEHICLE

Registration No:	Make & Model:	Year	Left Hand Drive: ☐
Chassis No.	Engine No	C.C.	Right Hand Drive: ☐

Colour:	Condition of Tyres:	Has the vehicle been involved in an accident before? ☐ Yes ☐ No
Was there any unrepaired damage prior to the accident?		If so give details
Name and Address of any Bank or Company financially interested in the vehicle:		
Class of Road Licence: ☐Car ☐Van ☐Truck ☐Omnibus ☐Motorcycle ☐Special Type		

D. PARTICULARS OF USE

State fully the purpose for which the vehicle was being used at the time of the accident	
Were goods being carried? Yes ☐ No ☐	If so state the a. Type of goods: b. Owner : c. Weight of the load:
How many persons were being conveyed in the vehicle?	Were they charged a fee to be conveyed?
Did the driver have permission from the insured to drive the vehicle? Yes ☐ No ☐	What is the relationship of the driver to the Insured?

(IN ALL CASES WHERE YOUR VEHICLE IS DAMAGED AND YOU ARE ENTITLED TO CLAIM UNDER THE POLICY, PLEASE SEND AT ONCE TO THE COMPANY AN ESTIMATE OF REPAIRS).

F. PARTICULARS OF PERSON DRIVING

Driver's Name:		Occupation:
Driver's Home Address:		Date of birth:
Sex: Male : ☐ Female: ☐	Telephone No.	Cellular Phone No:
Driver's Licence No.:	Date Issued:	Date of Expiry
Classes of vehicles licenced to drive:		Has it been endorsed? Yes ☐ No ☐
Is he/she employed by you to drive? Yes ☐ No ☐		If so, give particulars
Has he/she been involved in an accident in the past three years? Yes ☐ No ☐ If yes, give details of each accident below:-		
Does he /she own a vehicle? Yes ☐ No ☐		If yes, where is it insured?

Has he/she ever been refused insurance or the continuance thereof? Yes ☐ No ☐	
Has he/she convictions for any offence in connection with any motor vehicle?	If yes give details including dates
Does he/she suffer from any physical infirmity defective vision or hearing? Yes ☐ No ☐	Give details if any:

E. PARTICULARS OF DAMAGE TO OWN VEHICLE

Was the vehicle damaged? Yes ☐ No ☐ If so, state:-	
Nature of damage:	Location of Vehicle:
Approximate cost of the repair: $	Name of Repairer:

G. PARTICULARS OF ACCIDENT

Date of accident:	Time: a.m. p.m.	Place:
In your opinion on whom should blame be placed?		
Did the Police investigate or take particulars? Yes ☐ No ☐	If so, state name and number of police officer and the station concerned:	
Condition of Road	Nature of surface: (Paved/Unpaved)	Weather condition
Direction of Travel?	On which side of the road were you?	On which side of the road was the Third Party?
What was your speed before the accident?	What was your speed after the accident?	Did you sound your horn? Yes ☐ No ☐
Were your lights on, off, dim or bright?	Was the Seatbelt or Crash Helmet worn at the time of this accident? Yes ☐ No ☐	

H. PARTICULARS OF PASSENGERS IN INSURED'S VEHICLE:

Name	Age	Address	Occupation	Relationship to the Insured	Nature of Injury, if any and hospital attended.

I. PARTICULARS OF THIRD PARTIES

	Vehicle 1.	Vehicle 2.	Vehicle 3.
Driver's Name			
Driver's Address:			
Telephone Number			
Registration Number			
Vehicle Make & Model			
Owner's Name			
Owner's Address			
Insurer			
Nature of Damage			
Approximate cost of Repairs			
How many passengers were in the vehicle?			

Were the persons in the vehicle injured? Yes ☐ No ☐	If so, state their names , addresses and details of their injuries:-

Name and Address	Occupation	Nature of Injury

State other damage done by your vehicle to property (such as walls, fences, cultivations, animals). Gives name and address of owner and details of damage:-			
Name	Address	Description of Damage	Estimated Cost or Repairs

NAMES & ADDRESSES OF WITNESSES (other than passengers) :-			
Name	Address	Telephone Number	Position at Accident Scene

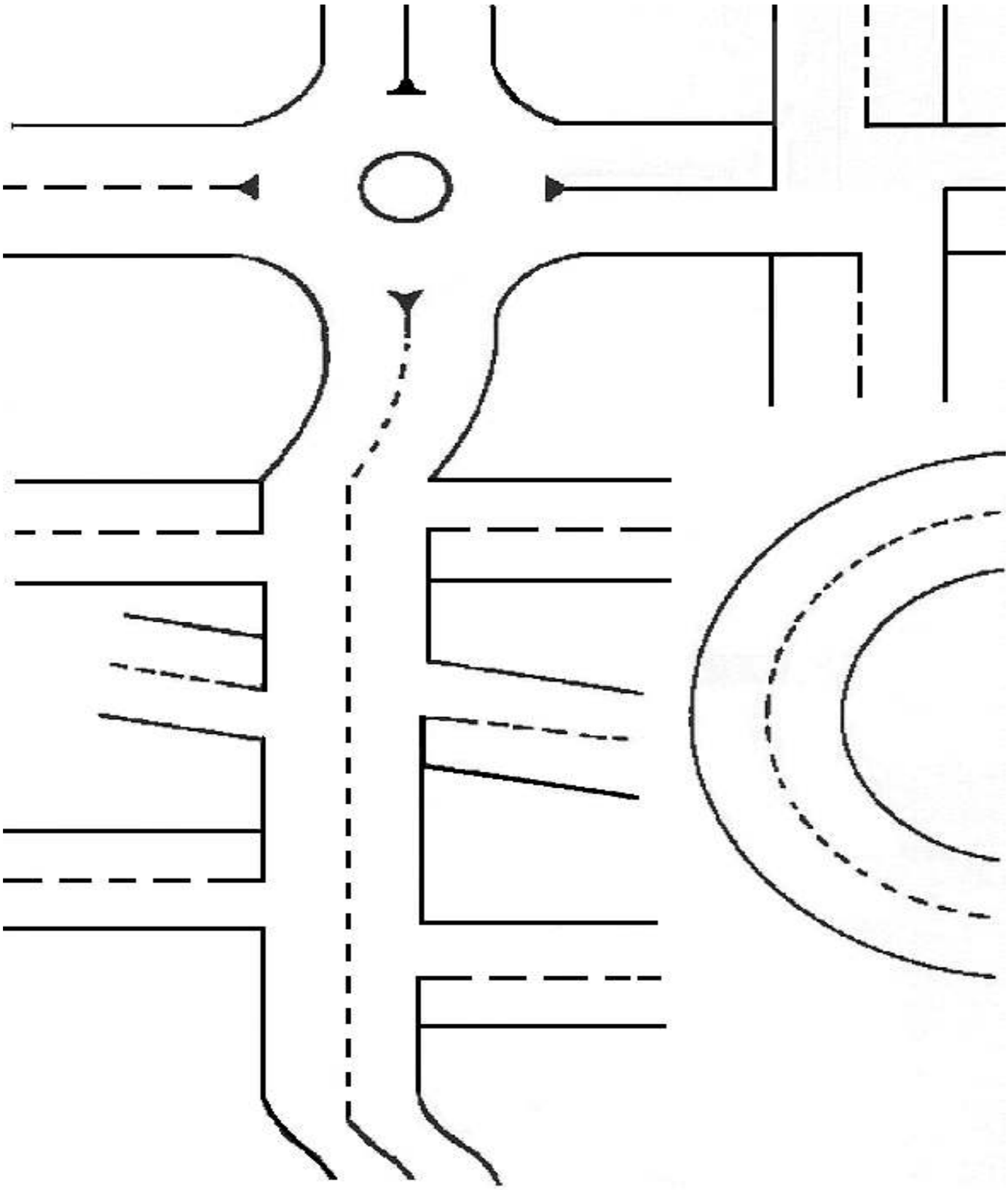
STATE FULLY WHAT HAPPENED AND SHOW BY SKETCH OVERLEAF POSITIONS OF VEHICLES AT TIME OF ACCIDENT. STATEMENT TO BE COMPLETED BY DRIVER ONLY

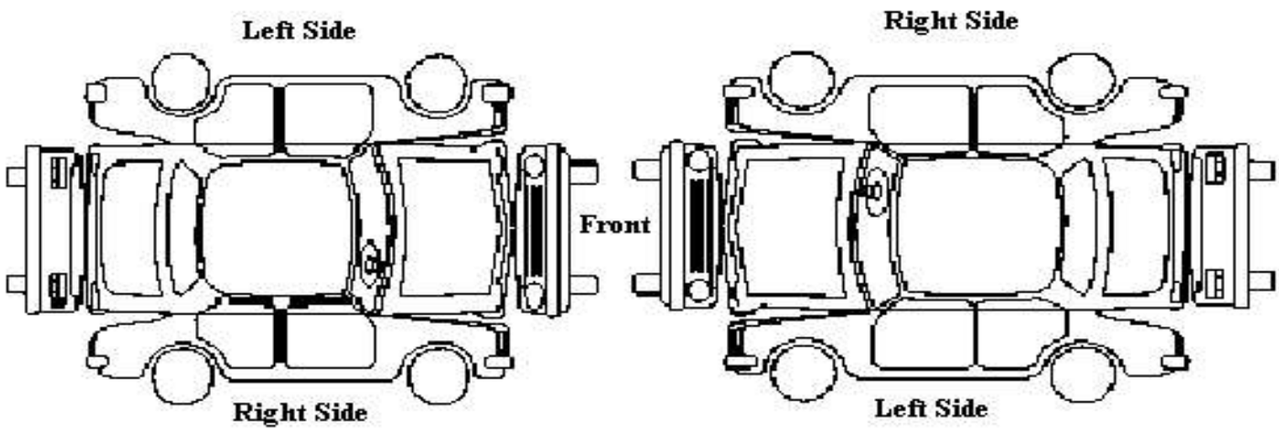
CLAIMS Has any claim been made upon you?
(Any communications that you receive about the accident should not be answered, but sent to the Company immediately)

I/We hereby DECLARE that the above particulars are true and complete to the best of my/our knowledge and belief.

Signature of Insured_____ Dated _____

Signature of Driver _____ Dated _____





Shade Damage to Your Vehicle

Shade Damage to Third Party's Vehicle