



MOTOR VEHICLE CLAIM FORM

info@tcifirst.com
ds@tcifirst.com

Tel. 649.946.4431

INSURED

Policy Number

Insured's Name

Address

Date of Birth

Telephone Number

Business/Occupation

Employer and Business Address

Business Telephone Number

Type of Policy/Type of Cover

Period of Cover

Year, Make and Model of Vehicle

Registration No./Vin No.

Insured Value of Vehicle

Do you have any other insurance on this vehicle?

Does any Financial Company have an interest?

If yes, who?

THE ACCIDENT

Date and Time of Accident

Were you in the vehicle at the time?

How many people in the vehicle at the time?

What was the weather conditions?

Where did the event occur?

Direction of Travel?

On which side of the road?

Speed at the time of the accident?

Purpose for which the vehicle was being used?

Was the accident reported to the police?

Did the police attend the event?

Police Officer's name and number

If known, state name and address of person causing the loss or damage

Were goods being carried?

If yes, description of goods

THE DRIVER

Name

Address and Telephone Number

Occupation

Employer

Driver's Licence number

Date Licence issued

Date of Birth of the Driver

Is the Driver a learner?

Been involved in an accident in the last five years,

yes / no

If yes, provide details

Been refused insurance or renewal?

yes / no

Any driving conviction?

Who was seated immediately beside the driver?

Name and Address of Passengers

DAMAGE OR LOSS

Was the Insured vehicle damaged?

yes / no

If yes, Nature of Damage

Estimated cost of repairing damage

Was any other vehicle or property damaged?

If yes, nature of damage

Estimated cost of repairing other damage

Name of Owner of the other property

Was anybody in the event injured?

yes / no

If yes, provide details

THIRD PARTY DETAILS

Owner's Name

Owner's Address and Telephone Number

Driver's Name

Driver's Address and Telephone Number

Year, Make and Model of other Vehicle

Registration Number of other Vehicle

How many Passengers were in the Vehicle?

Insurance Company

WITNESSES

Name

Address and Telephone Number

Name

Address and Telephone Number

STATEMENT

State fully the particulars of the accident. Statement should be completed by Driver.

YOUR DUTY TO US:

All communication relating to this event must be sent to us immediately by you.
Do not admit liability or give any written undertaking to any Third Party concerning this event.
Please provide us with an Insured/Driver's statement.

EXCESS:

Please note that where your own vehicle is insured, the excess; this is the amount you have pay, which is the first amount of any claim; will apply before final settlement.
Where there are other amounts owing by you to us for your insurances on this policy or others, such amounts will be deducted from your final settlement.

VEHICLE VALUATION:

Please note that at the time of loss, the value of the vehicle is understood to be the " current market value" of the vehicle. The market value is what a vehicle of the same type of a similar age and description would be worth at the time of an event. This may be less than the insured value.

DECLARATION

I/We declare that these particulars given by me/us have been read over and found to be true and correct in every respect, and I/We agree that if I/We have made or in any further declaration the Company require in respect of the said accident, shall make any false or fraudulent statement, or any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or future accident, shall be forfeited.

Signature of Driver

Date of Drivers signing

Signature of Insured

Date of Insured signing