

MOTOR VEHICLE LOSS OR DAMAGE

Claim Form

INSURED

Name of insured

Policy number

Contact person

Contact phone number

Contact email address

VAT number

INCIDENT

Incident type

Was the driver tested for
alcohol or drug abuse?
(where applicable)

YES

NO

Date & time of incident

If the driver was tested for
alcohol/drug abuse is the
report attached?

YES

NO

Date & time discovered

Is the incident covered under
any other policy of insurance?

YES

NO

Date & time reported

Place of loss

What purpose was the
vehicle used for

Speed at impact
(where applicable)

Weather/visibility

POLICE

Place where reported

Date of reporting

Case number (if reported)

VEHICLE DETAILS

| | |
|--|--|
| Make | |
| Model | |
| Year | |
| Registration number | |
| VIN number | |
| Chassis number | |
| Kilometers completed | |
| Details of outstanding finance | |
| Security fitments (immobilizer / tracking devices) | |

FULL DETAILS OF DRIVER

| | | | |
|--|--|--|--|
| Full name | | Does the driver have any disabilities including eyesight deficiency? | |
| ID / passport number | | Description of disability | |
| Occupation | | | |
| Was the driver using the vehicle with the insured's permission | | | |

WITNESSES

| | |
|------------------|--|
| Witness 1 | |
| Name | |
| Contact number | |
| Address | |

WITNESSES

| | |
|------------------|--|
| Witness 2 | |
| Name | |
| Contact number | |
| Address | |

SKETCH OF EVENTS RESULTING IN LOSS OR DAMAGE

DESCRIPTION OF EVENTS RESULTING IN LOSS OR DAMAGE

[Redacted area for description of events resulting in loss or damage]

INJURIES - INSURED VEHICLE OCCUPANTS

CONTACT DETAILS OF INJURED PERSON

Name

[Redacted area for contact details of injured person]

Contact person

Contact phone number

Contact email address

Description

MMF Accident form attached?

[Redacted area for MMF Accident form attached]

MMF Accident form submitted within 14 days of accident?

[Redacted area for MMF Accident form submitted within 14 days of accident]

Are the injured occupants of the insured vehicle employees of the insured?

[Redacted area for injured occupants employees of insured]

If the injured occupants of the insured vehicle were employees of the insured, what was the purpose of the trip?

[Redacted area for purpose of trip]

DESCRIPTION OF PERSONAL INJURIES TO OCCUPANTS OF INSURED VEHICLE

Name

[Redacted area for description of personal injuries to occupants of insured vehicle]

Contact person

Contact phone number

Contact email address

Full description of injuries

THIRD PARTY DETAILS

CONTACT DETAILS OF THIRD PARTY

Name

Contact person

Contact phone number

Contact email address

Insurer details

Policy number

VEHICLE DETAILS

Make

Model

Year

Registration number

VIN number

Chassis number

Details of damage to
third party vehicle

DESCRIPTION OF PERSONAL INJURIES TO OCCUPANTS OF THIRD PARTY VEHICLE

Name

Contact person

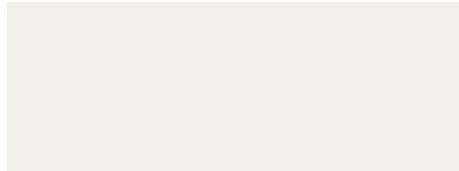
Contact phone number

Contact email address

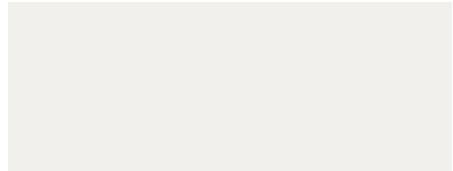
Full description of injuries

DECLARATION

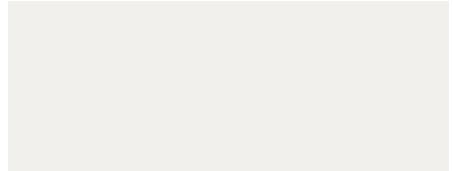
I / we declare that to the best of my / our knowledge the above statements are true. I acknowledge that the information set out above is provided freely so that Western may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Western may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim and take all necessary steps ancillary thereto to give effect hereto. I understand that I may be liable for output VAT in terms of section 8(8) of the VAT Act 89 of 1991.



Insured's signature



Capacity



Date

Cape Town
T 021 914 0290
F 021 914 0290
E info@westnat.com

Gauteng
T 012 523 0900
F 012 523 0909
E info@westnat.com

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T 044 011 0049
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