

MOTOR ACCIDENT CLAIM FORM

Minet Namibia Insurance Brokers (Pty) Ltd
Risk Consultants and Insurance Brokers

MOTOR ACCIDENT CLAIM FORM

(TO BE COMPLETED AND SIGNED BY CLAIMANT)

Insured Name	<input type="text"/>	Policy Number	<input type="text"/>
Occupation	<input type="text"/>	Contact Number	<input type="text"/>
Insured Address	<input type="text"/>		
Agent Name & No	<input type="text"/>	Agent Reference	<input type="text"/>

PARTICULARS OF VEHICLE

Make & Model	<input type="text"/>	Year	<input type="text"/>	Registration No	<input type="text"/>
Odometer Reading	<input type="text"/>	Sum Insured	<input type="text"/>	Date of Purchase	<input type="text"/>
Hire Purchase / Credit or Leasing Agreement Detail (if applicable). State Name and address of Financier.					
<input type="text"/>					

DAMAGE TO VEHICLE

Damage to own vehicle	<input type="text"/>	Estimated repairs (or attach quotation)	<input type="text"/>
Repairer's name, address & contact no	<input type="text"/>	Where can the vehicle be inspected?	<input type="text"/>

DRIVER DETAILS

Full Name	<input type="text"/>	Date of Birth	<input type="text"/>	Occupation	<input type="text"/>
Address	<input type="text"/>			Was he/she in your employ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Driver's License	Number	Date Issued	Place Issued	Code	License Type
(Copy to be attached)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Full <input type="checkbox"/> Learner
State fully the purpose for which the vehicle was being used					
<input type="text"/>					
Has he/she any motor insurance on own car?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, state Policy No. and Company			
<input type="text"/>					
Detail of any convictions for motoring offences	<input type="text"/>				
Has licence ever been endorsed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, state detail			
<input type="text"/>					
Does he/she have any physical defects?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, state detail			
<input type="text"/>					
Details of previous accidents					
<input type="text"/>					

PASSENGERS IN INSURED VEHICLE

Passenger Name	Address	Injury
<input type="text"/>	<input type="text"/>	<input type="text"/>
For what purpose were they being transported?		Are they employees?
<input type="text"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO

DAMAGE TO OTHER VEHICLES

Registration No.	Make & Model	Name & Address of Owner & Driver	Detail of Damage
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DAMAGE TO PROPERTY OTHER THAN VEHICLES

Name and address of Owner	Details of damage
<input type="text"/>	<input type="text"/>

