

MOTOR VEHICLE ACCIDENT REPORT FORM



Claim No.

The information required in this form is sought in the bona fide belief that litigation may ensue, and for the purpose of furnishing to the Solicitors of the Company information to enable them to advise us on behalf of the Insured in anticipation of litigation.

Please answer all questions fully

POLICY

Policy No : Period of insurance : From To

Terms of insurance : Excess, if any : Insured value :

INSURED - Applicable to individuals

Name :

Occupation : Address :

Telephone No : (H)

(M) Fax :

(O) Email :

INSURED - Applicable to Registered Companies

Name of Company :

Registered Address :

Name and Position :

Phone : (DL) E-mail :

(M) VAT Registration Number :

(F) Business Registration Number :

VEHICLE

Registration number :

Make : Cubic capacity : Year of make :

Type of body :

PURPOSE OF USE AT TIME OF ACCIDENT

For what purpose was the vehicle being used?

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If used for the carriage of goods or passengers :

State (1) Class of licence held :

(2) Usual capacity of the vehicle :

(3) Load at time of accident :

DRIVER

Name :

Address :

Date of birth :

Driving licence No :

Does your Driving Licence allow you to drive the insured vehicle? Yes No

Have you been concerned in any previous accidents? *(If yes, give number)* Yes No

Have you any physical defects? *(If yes, give details)* Yes No

Have you been prosecuted for any motoring offences? *(If yes, give details)* Yes No

Are you in the Insured's employment? *(If yes, in what capacity and for how long?)* Yes No

If you are not in the Insured's employment, what is your relationship with the Policy holder?
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PARTICULARS OF ACCIDENT

Date : Time : Place :

State of weather : and light at time of accident

If dark, were your headlamp alight?

What was the width of the road? What was the condition of the road?

Were any Traffic Lights in operation at scene of accident? *(If yes, were they in your favour?)* Yes No

Was your vehicle on the main road? Yes No

How far from the kerb or near side of the road?

At what speed was your vehicle travelling at time of accident?

What warning did you give?

In case you filled an Agreed Statement of Facts, do you believe that according to the circumstances of the accident that you are at fault? Yes No

In case the accident was reported to the Police, do you believe that you are at fault? Yes No

Please give full description of accident and events leading up to the accident
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WITNESSES OF ACCIDENT (it is of the utmost importance always to obtain names and addresses of witnesses)

Please state full names and addresses of persons who were travelling in the vehicle at the time of accident :

(a)

(b)

Names and addresses of INDEPENDENT witnesses :

(a)

(b)

Was an Agreed Statement of Facts (ASF) filled after the accident? Yes No

Have you reported the Accident to Police Station? (If yes, which police station?) Yes No

If a Police officer witnesses the accident give his number:

Have you come to any mutual agreement with the other party as a result of the accident? Yes No

In case of no mutual agreement, did you fill a Minor Accident Report Form at the Police (PF179)? Yes No

DAMAGE TO INSURED'S MOTOR VEHICLE

If your Motor Vehicle has been damaged, please give full particulars :

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Probable Cost : Name of Approved Repairer :

(If possible an Estimate should accompany this Form but do not delay returning this Form if Estimate is not yet obtained).

NAMES OF ANY OTHER PARTIES CONCERNED IN THE ACCIDENT, AND DETAILS OF THEIR CLAIMS (IF ANY)

Name:

Occupation : Address :

If a vehicle, give registered no. and make :

Insurer's name :

Did any of them accept responsibility for the accident? Yes No

(If not, did they make any other statement?)

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Please give full details : Of their personal injuries:

Of damage to their property:

Has notice of any claim been given to you?

Were any Passengers in your Vehicle injured? Yes No

(If Yes, please give names and addresses and state extent of injuries:)

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If any person received treatment at scene of accident, or was taken to hospital, give his/her name and that of doctor and/or hospital:

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Please provide a SKETCH showing by arrows the respective courses of parties involved in accident and indicate position of any nearby pedestrian crossing and/or traffic signs.

DECLARATION

I/We hereby declare that the above statements and facts are true, and that I/We have not withheld from the company any information which is to my/our knowledge connected with the Accident.

Date:

Driver's Signature:

Insured's Signature:

FOR OFFICE USE ONLY

Claim form filled by :

Branch : Date : Time :

Sent by fax (213 4826) on : at :

Sent by e-mail (claims@mauritiusunion.com) on : at :

Original sent by despatch on : at :