

# Claim Form

## Vehicle Accident



**Please help us to help you by:**

- completing all relevant questions in full as this can avoid the need for further enquiry and possible delay in settling your claim
- signing and dating page 4 of this form

Issued by

Date

Office

**INSURANCE FRAUD IS A CRIME - PLEASE ENSURE ALL INFORMATION IS CORRECT**

### 1. Policyholder(s) details

Policy/Client number  Claim number (if known)

Full name Mr  Mrs  Miss  Ms

Postal address  Date of birth

Telephone Home  Business  Mobile

Email Home  Business

Occupation  Employer

### 2. Person driving or in charge of the vehicle (to be completed, even if parked)

Full name Mr  Mrs  Miss  Ms

Postal address

Telephone Home  Business  Mobile

Email Home  Business

Date of birth  Relationship to Policyholder

Occupation

(a) Are they the main driver of the Insured vehicle? Yes  No

(b) If not the Policyholder, does the driver own a vehicle? Yes  No

Insured with	Make/Model	Registration No.
<input type="text"/>	<input type="text"/>	<input type="text"/>

(c) 1. Has the driver had any other accident, loss or claim in connection with any vehicle during the past five years? Yes  No   
If Yes, please give details. Include the date and circumstances of accident/loss.

2. Has the driver ever been charged or convicted of any criminal or motoring offence or received any traffic infringement notice? Yes  No   
If Yes, please give all details. Include offence code.

3. Has the driver's licence been cancelled, suspended or endorsed at any time? Yes  No   
If Yes, please give details. Include penalty points.

4. Has the driver had any condition which could affect their fitness as a driver, e.g. diabetes, epilepsy, heart conditions, physical or mental illness or disability? If Yes, please give details below. Include daily dosage and the name of any drugs taken. Yes  No

(d) Within 12 hours before the accident, had the driver

1. Consumed intoxicating liquor? Yes  No  If Yes, state quantity

2. Taken any drug? Yes  No  If Yes, state type and purpose

(d) Within 12 hours before the accident, had the driver

1. Undergone a breath test? Yes  No  If Yes, state quantity  Positive  Negative

2. Undergone a blood test? Yes  No  If Yes, state type and purpose

### 3. Insured vehicle

(a) Vehicle registration no.  Make/Model  CC rating   
Warrant of fitness no.  Expiry date  Issued by   
Year of manufacture  Date of purchase  Purchase price \$

(b) Name and address of registered owner:

(c) Is the vehicle the subject of any hire, lease or finance agreement including hire purchase? Yes  No   
If Yes, please give name and address

(d) Has the vehicle been modified in any way? Yes  No   
If Yes, please give details

(e) Is there any other insurance on the vehicle or its accessories? Yes  No   
If Yes, please give details

### 4. Use of the insured vehicle

(a) Was the vehicle being used with the policyholder's knowledge and permission? Yes  No   
If No, give full details

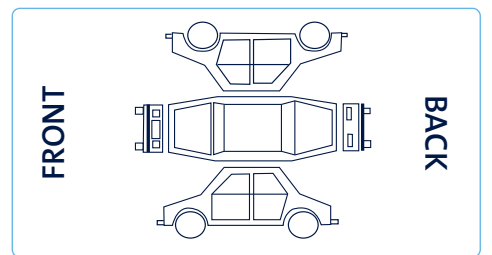
(b) State the exact purpose for which the vehicle was being used at the time of the accident ("Private" is not sufficient)

### 5. Damage to insured vehicle

(a) Give particulars of damage and estimated cost of repairs (if known)

Estimated cost of repairs  \$

Indicate damaged areas below:



(b) Was there any unrepaired damage or rust in the vehicle immediately prior to the accident? Yes  No   
If Yes, please advise where and what:

(c) Name and address of repairer   
Telephone number

(d) Is the vehicle still in use? Yes  No   
If No, where is the vehicle now?

(e) Who should we contact to make any appointment to inspect the vehicle?  
Name and address   
Telephone number

## 6. Accident details

What, in your opinion, caused the accident?

(a) Date  Time  am  pm  Was it... Daylight?  Dusk?  Dark?  (tick one)

(b) Location of accident (Street/Town/City)

(c) Weather Fine  Bright sun  Light rain  Heavy rain  Overcast  Fog

(d) Condition of road surface Wet  Dry  Gravel  Seal  Other

(e) Lighting on your vehicle Not on  Park  Dip  Full

Lighting on third party vehicle Not on  Park  Dip  Full

Was any street lighting switched on? Yes  No

(f) What speed limit was in force?  What was your speed?

(g) Description of accident circumstances:

(h) Explanatory sketch: (please indicate the layout of road(s) and approximate measurements; names of street(s)/road(s); position of vehicles and persons involved; the direction in which vehicles were travelling; the registration marks of all vehicles, where known; any road markings, road signs, traffic lights, street lights, pedestrian crossings)

Your vehicle

Other vehicle

## 7. Police

(a) (i) Was the accident reported to the Police? Yes  No

(ii) Did the Police attend the scene of the accident? Yes  No

If Yes, name/number of officer  Station

(b) Have the police issued a Notice of Intended Prosecution, or given any verbal warning? Yes  No

If Yes, to who and for what alleged offence?

## 8. Details of driver's licence

(a) Licence number

(b) Type of Licence Full  Learners  Restricted

(c) For what classes of driving is it valid?  Issued by  Date of birth

## 9. Witnesses - including all passengers travelling in your vehicle

If there were no witnesses, please write "NONE"

Name and Telephone Number	Address	Where was the witness at the time of the accident?

## 10. Other vehicles involved

Has a claim been made on you? Yes  No  If no other vehicles were involved, please write "NONE"

Name, address & telephone number of owner/driver	Make/Model	Registration No	Apparent damage	Insurers & Policy No.

## 11. Other property involved

Has a claim been made on you? Yes  No  If no other vehicles were involved, please write "NONE"

Name, address & telephone number of owner	Description of property and apparent damage	Insurers & Policy No

## 12. Direct crediting authority

If your claim is accepted and there are payment(s) to you, we can pay this amount direct into your bank account by direct credit. If you would like us to make this direct credit, please complete details below. You will be advised if a payment has been made following acceptance of your claim.

Do you wish to use this facility? Yes  No  Name of Account

I/We authorise the payment to be made into this bank account. (Please attach a deposit slip)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bank	Branch	Account Number	Suffix

## 13. Indemnity request

Please deal with all claims arising from this accident on my/our behalf. I/we acknowledge that you have full discretion in conducting the defence or settlement of any claim and in prosecuting in my/our name any claim for indemnity or damages.

I/We agree that, if the policy covers the cost of repairs to the Insured vehicle, you may authorise these repairs on my/our behalf by the repairer named above, or by such other repairer to who the vehicle has been submitted with my/our permission; alternatively, you may move the vehicle to safe storage.

## 14. Declaration/Privacy Act 1993/Insurance Claims Register

I/We declare that to best of my/our knowledge and belief these particulars are complete and correct.

I/We

- agree to give any further information that may be required;
- understand you require this personal information, which will be retained by you at 48 Shortland Street, Auckland before you can evaluate my/our claim;
- authorise the disclosure of this personal information regarding this claim to other parties;
- authorise the obtaining by you from any other party personal information about me/us that is in your view relevant to this claim;
- authorise the obtaining by you from Insurance Claims Register Limited (ICR Ltd), which holds details of claims made by me/us under policies with other insurers, personal information about me/us that is in your view relevant to this claim;
- authorise you to place details of this claim on the database of ICR Ltd, PO Box 474, Wellington, where it will be retained and be available to other insurance companies to inspect;
- understand that I am/we are entitled to certain rights of access to and correction of the personal information held by you and ICR Ltd.

The collection of this information is required under the terms of your policy. Failure to provide it may result in your claim being declined.

Date

**Signature of the Policyholder(s) (If the policy is in joint names, both signatures are required)**

Date

**Signature of the driver or person making the claim**

Please return this completed claim form to: PO Box 1093, Wellington or scan and email to [newclaims@ampg.co.nz](mailto:newclaims@ampg.co.nz), or fax toll free 0508 498 8378.  
Phone toll free 0508 806 244.

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