

# Claim Form

## Vehicle Accident - Uninsured Parties



The making of a false representation with a view of obtaining benefit under an insurance policy constitutes an offence under the Crimes Act 1961.

Note: Please answer all questions - "dashes" are not sufficient and may cause delay.

If known, please show our client's policy number.

Issued by

Date

Office

### 1. Our policyholder (against whom you wish to claim)

Full name Mr  Mrs  Miss  Ms

Address

Telephone Home  Business  Mobile

Email Home  Business

Occupation

### 2. Person driving or in charge of our policyholder's vehicle (if not as in 1.)

Full name Mr  Mrs  Miss  Ms

Address

Telephone Home  Business  Mobile

Occupation

### 3. Our policyholder's vehicle

Make/model

Registered number  Approximate year of manufacture

### 4. Your details (owner of vehicle)

Full name Mr  Mrs  Miss  Ms

Address

Telephone Home  Business  Mobile

Date of birth

Occupation

### 5. Details of driver of your vehicle (if not you)

Full name Mr  Mrs  Miss  Ms

Address

Telephone Home  Business  Mobile

Date of birth  Relationship to owner of vehicle

Occupation

### 6. 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  Expiry date

## 7. Your vehicle

(a) Warrant of Fitness number  Issued by  Expiry date   
Vehicle registration number  Make/model  CC rating   
Year of manufacture  Date purchased  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 the name, address and reference of the company:

(d) Is there any insurance on the vehicle or its accessories? Yes  No

If Yes, please give details below:

## 8. Accident details

What, in your opinion, caused the accident?

Did our policyholder make any admission of liability for the accident? Yes  No

If Yes, what did they say?

(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 our policyholder's 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

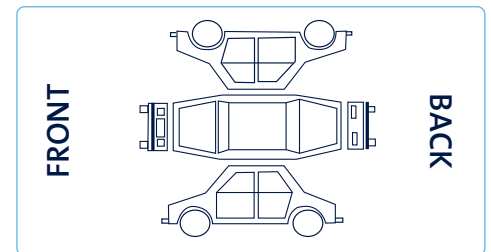
## 9. Damage to your vehicle

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

Estimated cost of repairs

\$

Indicate below damaged areas:



Yes  No

(b) Was there any unrepaired damage or rust in the vehicle immediately prior to the accident?

If Yes, please advise details.

(c) Repairer's name and address

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

Address

Telephone number

Business

Home

## 10. 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?

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

If there were no witnesses, please write "NONE"

Name	Address and telephone number	Where was the witness at the time of the accident?

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

My above named vehicle is    uninsured     insured for third party property only

AMP's general insurance products are underwritten by Vero Insurance New Zealand Limited (Vero)

I/We understand that provision of this form by Vero and completion of this form does not constitute any admission of liability by Vero either under the policyholder's insurance policy or otherwise.

- I/We
- (a) agree to give any further information that may be required;
  - (b) understand you require this personal information, which will be retained by you at 48 Shortland Street, Auckland before you can evaluate my/our claim;
  - (c) authorise the disclosure of this personal information regarding this claim to other parties;
  - (d) authorise the obtaining by you from any other party personal information about me/us that is in your view relevant to this claim;
  - (e) 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;
  - (f) 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;
  - (g) understand that I am/we are entitled to have certain rights of access to and correction of the personal information held by you and ICR Ltd.

I/We

of

declare that the information provided in this form is true and correct.

<input type="text"/>	Date <input type="text"/>
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**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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