

# MOTOR VEHICLE LOSS OR DAMAGE

## Claim Form

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### INSURED

Name of insured	<input type="text"/>
Policy number	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
VAT number	<input type="text"/>

### INCIDENT

Incident type	<input type="text"/>	Was the driver tested for alcohol or drug abuse? (where applicable)	<input type="text" value="-Please Select-"/>
Date and time of incident	<input type="text"/>		
Date and time discovered	<input type="text"/>	If the driver was tested for alcohol/drug abuse is the report attached?	<input type="text" value="-Please Select-"/>
Date and time reported	<input type="text"/>	Is the incident covered under any other policy of insurance?	<input type="text" value="-Please Select-"/>
Place of loss	<input type="text"/>		
What purpose was the vehicle used for	<input type="text"/>		
Speed at impact (where applicable)	<input type="text"/>		
Weather/visibility	<input type="text"/>		

### POLICE

Place where reported	<input type="text"/>
Date of reporting	<input type="text"/>
Case number (if reported)	<input type="text"/>

### VEHICLE DETAILS

Make	<input type="text"/>
Model	<input type="text"/>
Year	<input type="text"/>
Registration number	<input type="text"/>
VIN number	<input type="text"/>
Chassis number	<input type="text"/>
Kilometers completed	<input type="text"/>
Details of outstanding finance	<input type="text"/>
Security fitments (immobilizer / tracking devices)	<input type="text"/>

**FULL DETAILS OF DRIVER**

Full name

ID / passport number

Occupation

Was the driver using the vehicle with the insured's permission

Does the driver have any disabilities including eyesight deficiency?

Description of disability

**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

## INJURIES - INSURED VEHICLE OCCUPANTS

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### CONTACT DETAILS OF INJURED PERSON

Name	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Description	<div style="background-color: #f0f0f0; height: 80px;"></div>

MMF Accident form attached?	<input type="text" value="-Please Select-"/>
MMF Accident form submitted within 14 days of accident?	<input type="text" value="-Please Select-"/>
Are the injured occupants of the insured vehicle employees of the insured?	<input type="text" value="-Please Select-"/>
If the injured occupants of the insured vehicle were employees of the insured, what was the purpose of the trip?	<div style="background-color: #f0f0f0; height: 40px;"></div>

### DESCRIPTION OF PERSONAL INJURIES TO OCCUPANTS OF INSURED VEHICLE

Name	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Full description of injuries	<div style="background-color: #f0f0f0; height: 100px;"></div>

# THIRD PARTY DETAILS

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## CONTACT DETAILS OF THIRD PARTY

Name	
Contact person	
Contact phone number	
Contact email address	
Insurer details	
Policy number	

## VEHICLE DETAILS

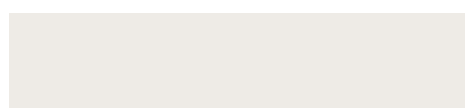
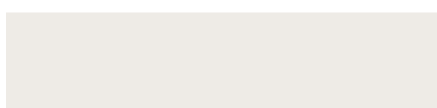
Make	
Model	
Year	
Registration number	
VIN number	
Chassis number	
Details of damage to third party vehicle	

## 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 the Value-Added Tax Act, 10 of 2000.

		
Insured's signature	Capacity	Date

### Cape Town

T 021 914 0290  
F 021 914 0293  
E info@westnat.com

### Gauteng

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

### Windhoek

T +264 (0) 61 256 733  
F +264 (0) 61 251 056  
E info@westnat.com