



LOCKTON®

MOTOR VEHICLE CLAIM

The issue of this form does not constitute an admission of liability on the part of the insurer.

Please complete in full all sections of this claim form and return it as soon as possible after the accident.

Policy Number		ABN Number	
Have you claimed an input tax credit on the GST applicable to this policy? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, state percentage claimed			%

INSURED DETAILS			
Name of Insured			
Address			State
			Postcode
Contact Numbers	Phone ()	Mobile	()
Occupation			
Are you the sole owner of the insured vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/> - If No, name of other interested parties			
Is the vehicle leased? No <input type="checkbox"/> Yes <input type="checkbox"/>		Type of lease: Novated <input type="checkbox"/> Other <input type="checkbox"/>	

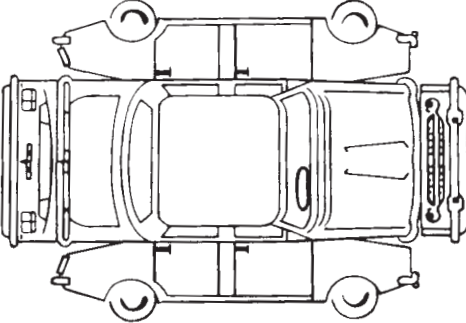
INSURED VEHICLE			
Make & Model		Year	Fleet No.
Rego	Engine No.	Chassis / VIN number	
CLASS OF VEHICLE			
Sedan or Station Wagon <input type="checkbox"/>	Four Wheel Drive <input type="checkbox"/>	Heavy Plant <input type="checkbox"/>	Rigid Vehicle over 2T and up to 5T <input type="checkbox"/>
Van or Utility up to 2T <input type="checkbox"/>	Bus or Coach <input type="checkbox"/>	Articulated Prime Mover <input type="checkbox"/>	Rigid Vehicle over 5T and up to 10T <input type="checkbox"/>
Semi Trailer <input type="checkbox"/>	Light Plant <input type="checkbox"/>	Heavy Plant <input type="checkbox"/>	Other
Trailer #1 Details (if applicable)	Make	Type	
Year	Rego No.	Fleet No.	
Trailer #2 Details (if applicable)	Make	Type	
Year	Rego No.	Fleet No.	
State any non-standard accessories/modifications to vehicle?			
State time and place journey commenced and intended destination			
State type of goods being carried?			

DRIVER - For Parked or Unattended vehicles, Driver or Vehicle Custodian at the time of loss.			
Surname		Given Name(s)	
Address			Postcode
Contact Numbers	Phone ()	Mobile	()
Date of Birth	Age	Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Current Driver's Licence No. and endorsements			
Expiry Date	/ /	Years Licenced to drive this type of vehicle	

DRIVER - Continued

Name of Registered Owner of the Vehicle (If not insured)			
Drivers relationship to the insured		Was the vehicle being used with the owners consent? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you had any traffic convictions and/or traffic offences or been involved in any motor vehicle accidents in the past five (5) years?		No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details	
How many hours have you spent driving in the 48 hours immediately preceding the accident?			
Did you consume any alcohol or take any drugs during the 12 hours prior to the accident?		No <input type="checkbox"/> Yes <input type="checkbox"/> - If Yes, state what, how much and when	
Did you undergo a breath test or blood test for alcohol or drugs?		No <input type="checkbox"/> Yes <input type="checkbox"/> - If Yes, what was the result	
Did you refuse to undergo any of the above tests?		No <input type="checkbox"/> Yes <input type="checkbox"/>	

DAMAGE TO INSURED VEHICLE

Was your vehicle damaged?		No <input type="checkbox"/> Yes <input type="checkbox"/>	
Was your vehicle towed away?		No <input type="checkbox"/> Yes <input type="checkbox"/> - If Yes, name of company	
Have you obtained a repair quote?		Quote	\$ (Attach all quotes)
Who is your preferred repairer?			
Is the vehicle there?		No <input type="checkbox"/> Yes <input type="checkbox"/> - If not, where is the vehicle located? (Full address)	
		Phone	()
Show the damaged areas to your vehicle on the following diagram <div style="text-align: center;">  </div>			

ACCIDENT DETAILS

Date	/ /	Time	am / pm	Vehicle Use:	Business <input type="checkbox"/>	Private <input type="checkbox"/>							
DAY OF THE WEEK													
Monday	<input type="checkbox"/>	Tuesday	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>	Friday	<input type="checkbox"/>	Saturday	<input type="checkbox"/>	Sunday	<input type="checkbox"/>
LOCATION	Street		Suburb		Postcode								
How did the incident or theft happen?													

ACCIDENT DETAILS - Continued

Please draw a plan of the accident. Show the nearest cross street; street names; centre of the roadway; direction and location of vehicles. It is important to detail all road signs and marking and width of road.

Indicate your own vehicle as A Indicate any other vehicles as B

Who do you consider was at fault? Myself Other Driver Other

Why?

Estimated speed of your vehicle at impact (Kilometres per Hour)

Estimated speed of the other vehicle just before the accident (Kilometres per Hour)

What lights if any were being used by you?

What lights if any were being used by the other party?

What signals were given by you?

What signals were given by the other party?

State of road / road surface Smooth Rough Wet Dry Uphill Downhill Flat

How was visibility? Good Moderate Poor

Were there any independent witnesses to the accident? No Yes - If Yes, please provide names and addresses

POLICE QUESTIONS

Did a Police Officer attend the accident scene? No Yes

Or did you report the incident to the police? No Yes - Give details

Name Rank

Station

Date of report **PLEASE ATTACH A COPY OF POLICE REPORT, IF AVAILABLE**

Name of person to be charged or cautioned

Nature of charge or caution

WITNESS(ES) DETAILS

Surname Given Name(s)

Address

State Postcode

Contact Numbers Phone () Mobile ()

Was this witness in the insured vehicle? No Yes

Surname Given Name(s)

Address

State Postcode

Contact Numbers Phone () Mobile ()

Was this witness in the insured vehicle? No Yes

DAMAGE TO OTHER VEHICLE OR PROPERTY

	Vehicle or Property No. 1	Vehicle or Property No. 2
Vehicle Make & Model		
Rego No.		
Name of Other Driver		
Address		
Phone No.		
Licence No.		
Name of Registered Owner (if not driver)		
Address		
Phone No.		
The Other Insurance Company		
Policy Number		
Description of Damage		

PERSONAL INJURIES

Was this witness in the insured vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Name	Type of Injury	Injured Party (Passenger / Driver)	Vehicle (Registration No.)

PRIVACY

Lockton Companies Australia Pty Ltd includes information about how we manage your personal information in your financial services guide. You can obtain a copy of the insurers Privacy Policy Statement from their website.

DECLARATION AND AUTHORISATION

THE INFORMATION AND ANSWERS GIVEN ABOVE ARE TRUE, CORRECT AND COMPLETE IN EVERY DETAIL.

- I / We understand the claim may be refused if information is not true or withheld
- I / We authorise the insurer to give and obtain from other insurers, insurance references bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Signature of Insured	1.	<input style="width: 95%;" type="text"/>	Date	<input style="width: 95%;" type="text" value=" / /"/>
Signature of Insured	2.	<input style="width: 95%;" type="text"/>	Date	<input style="width: 95%;" type="text" value=" / /"/>

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM