

Motor Vehicle Claim Form



It is essential that this form be returned directly to Ansvar Insurance, with all questions answered, at the earliest opportunity. Please print your answers and where appropriate.

Office use only Claim number

1. Policyholder details

Name/Business name		Policy number			
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address				State	Postcode
<input type="text"/>				<input type="text"/>	<input type="text"/>
Telephone: Home	Telephone: Work	Telephone: Mobile	Fax number		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Email		Occupation			
<input type="text"/>		<input type="text"/>			

2. Insured Vehicle

Registration number	Year of manufacture	Make	Model
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Body type (eg. Sedan)	Odometer reading	Expiry date of registration	
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	

Has the vehicle been modified or fitted with accessories or optional extras other than those supplied at the maker's option?
 Yes No *If yes, describe the modifications/accessories*

Was there any unrepaired damage to the vehicle before the incident? Yes No *If yes, please provide details*

When was the vehicle purchased? / / Amount Paid \$

Is the vehicle under finance? Yes No *Name of finance company*

Amount outstanding \$

For what purpose was the vehicle being used at the time of the collision? eg. private use only, carrying goods in connection with business etc?

Was any other insurance (other than Compulsory Third Party Insurance) in force on the vehicle at the time of the collision?
 Yes No *If yes, state the name of the insurance company*









3. Person in charge of vehicle at time of loss

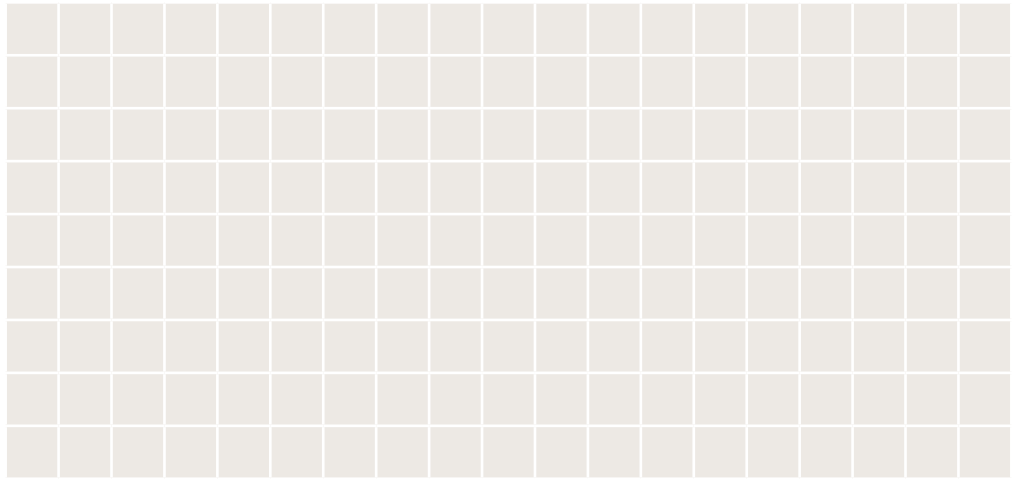
Name	Date of birth
<input type="text"/>	<input type="text"/>
Address	Telephone number
<input type="text"/>	<input type="text"/>

Victoria AD GPO Box 1655 Melbourne 3001 FX +61 3 9614 1545	New South Wales AD PO Box 1410 Parramatta 2124 FX +61 2 9687 9564	Queensland AD GPO Box 747 Brisbane 4001 FX +61 7 3221 6721	South Australia AD PO Box 630 Fullarton 5063 FX +61 8 8338 1920	Western Australia AD PO Box 840 West Perth 6872 FX +61 8 9324 2013	Tasmania AD PO Box 330 Launceston 7250 FX +61 3 9614 1545
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Please draw a diagram showing streets, position of vehicles, direction of travel, etc. Show north by arrow.

Symbols

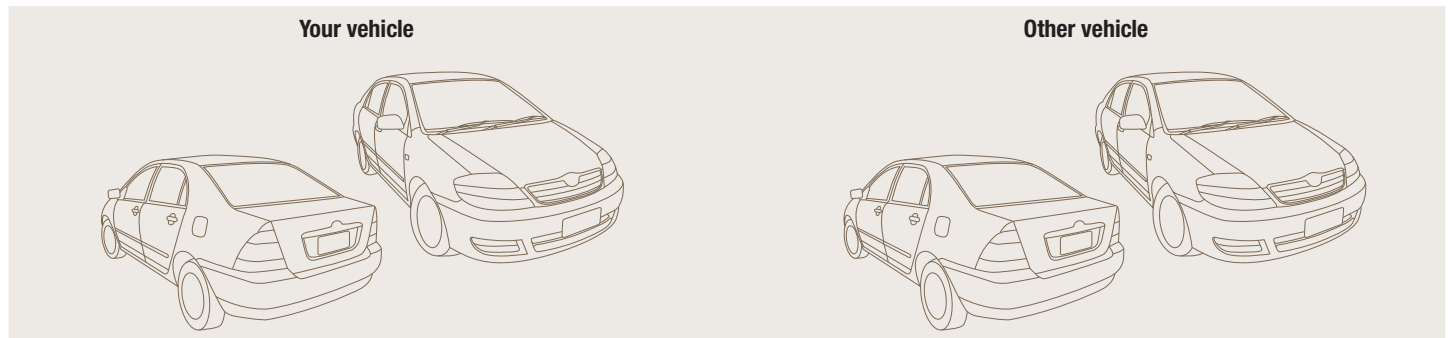
- Your vehicle 
- Other vehicle(s) 
- Lane arrows 
- Stop sign 
- Street intersection 
- Give way sign 
- Curved street 
- Traffic lights 



5. Damage to insured vehicle

Describe the damage to your vehicle directly resulting from this collision

On the diagrams show the point of impact by an 'X' and the areas damaged by shading



Is the vehicle in a drivable condition? Yes No Was the vehicle towed from the accident scene? Yes No

If Ansvar Insurance needs to inspect the vehicle, who do we contact and where will the vehicle be?

Name	Telephone number
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Address of vehicle	State Postcode
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/> <input style="width: 15%;" type="text"/>

6. Details of other vehicle or property

Details of other vehicle *If more than one vehicle involved, please provide similar particulars to that requested below on a separate sheet and attach to this form*

Registration number	Make	Model	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Driver's surname	Given names (full)	Approx age	Licence number
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>
Address	State	Postcode	
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	
Telephone: Home	Telephone: Business	Telephone: Mobile	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
Owner's full name (if not the driver)			
<input style="width: 100%;" type="text"/>			
Address	State	Postcode	
<input style="width: 100%;" type="text"/>	<input style="width: 15%;" type="text"/>	<input style="width: 15%;" type="text"/>	
Other vehicle insured with	Policy number		
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>		

Details of property Description of property (eg. building, fence, etc.)

Owner's name

Address

State

Postcode

Was there any damage to the other vehicle or property as a result of the collision? Yes No *If yes, complete below*

Description of damage to other vehicle or property

If any communication is received by you, please forward it immediately to this office

7. Witnesses

Were there any witnesses to the collision? Yes No *If yes, state the witness particulars*

Name of witness No.1

Address

State

Postcode

Telephone: Home

Telephone: Work

Telephone: Mobile

Type of witness

Passenger in your vehicle

Passenger in other vehicle

Independent eye witness

Name of witness No.2

Address

State

Postcode

Telephone: Home

Telephone: Work

Telephone: Mobile

Type of witness:

Passenger in your vehicle

Passenger in other vehicle

Independent eye witness

8. Police

Please attach the police report to this claim form

Were the police advised of the collision? Yes No *If yes, did the police attend the accident* Yes No

or the accident was reported to police station at / / on / /

And in both cases state the Officer's name and number

Police Report Number Was either driver charged with an offence? Yes No

If yes, indicate if: your driver and the offence

If yes, indicate if: other driver driver and the offence

Was either driver asked to take a blood/breathalyser test? Yes No *If yes, attach copy of results of test of your driver*

9. Goods and services tax

To ensure you do not incur any unnecessary GST liabilities on this claim complete these details

Are you registered for GST purposes? Yes No What is your ABN?

If you have registered and have an ABN, have you claimed or will you be claiming an input tax credit on the GST applicable to this policy? Yes No

Is the amount claimed less than 100% of the GST applicable to the premium? Yes No Specify the percentage amount claimed %

10. Electronic Funds Transfer

Settlement of your claim may involve a cash settlement. Please complete the following if you are interested in an EFT Payment

Account name

BSB number

Account number

11. I declare that all the information I have given is true and correct

Signature

Date

Ansvr Insurance is a member of the insurance industry's impartial Insurance Ombudsman Service. This independent service is provided to the insuring public at no cost and aims to resolve claims complaints quickly and informally. In the unlikely event of a complaint arising, you should firstly contact the local Ansvr Insurance Regional Manager. In most cases the problem will be resolved easily. If you are not satisfied with the response given by the Regional Manager you may contact our Internal Dispute Resolution Committee for advice and assistance in resolving your claim.

Privacy The information we collect assists us to make a decision on whether we will accept your claim. If you do not provide this information we may be unable to process your claim. We may use third party suppliers (agents, loss adjusters, assessors and mailing houses) to carry out specialised activities on your behalf. These organisations are aware of their obligations under Privacy provisions. At any time you may request access to your personal information and correct it if it is wrong. We value the personal information you give to us and we will take all reasonable precautions to prevent unauthorised access to this information.