



Motor Vehicle Claim (Non Theft)

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

Policy Number

Claim Number

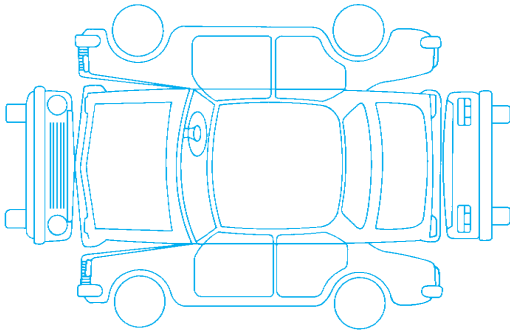
Please complete all sections. Important: Attach one quotation from repairer.

The Insured			
Full Name (Block Letters)	Surname	Given Name(s)	
Postal Address		State	Postcode
Are you registered for GST?	No <input type="checkbox"/> Yes <input type="checkbox"/>	What is your ABN?	
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	No <input type="checkbox"/> Yes <input type="checkbox"/>	– Will you be claiming an amount less than 100%?	
	No <input type="checkbox"/> Yes <input type="checkbox"/>	– Specify amount claimed	%
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No <input type="checkbox"/> Yes <input type="checkbox"/>	– Will you be claiming an amount less than 100%?	
	No <input type="checkbox"/> Yes <input type="checkbox"/>	– Specify amount claimed	%
Contact Numbers	Business	()	Private ()
	Facsimile	()	Mobile

Vehicle Details			
Make of Vehicle		Year	/ / Registered No.
Model		Colour	Odometer Reading
Registered Owner			
Address		State	Postcode
Do you owe money on your vehicle?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
Name of Lender		Account Number	
Address		State	Postcode

Driver Details			
Full Name (Block Letters)	Surname	Given Name(s)	
Address		State	Postcode
Contact Numbers	Business	()	Private ()
	Facsimile	()	Mobile
Relationship to Insured			
Licence Number		Expiry Date	/ / Date of Birth / /
How long has the driver been licensed for this type of vehicle?	years		
Did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
Did the driver undergo a breath test, breath analysis or blood test?	No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details		
What was the reading?	(Please attach copy of the certificate.)		

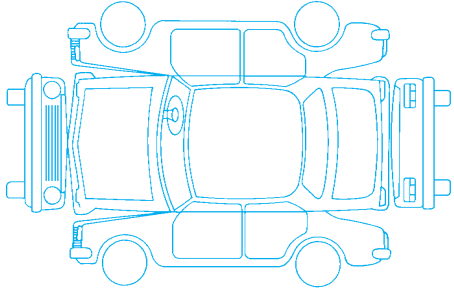
Incident Details					
Date	/ /	Day		Time	am/pm
Where did the incident happen?					
Street		Suburb		Nearest Cross Street	
Road surface: Dry <input type="checkbox"/> Wet <input type="checkbox"/> Loose <input type="checkbox"/>					
At the time of the accident the insured vehicle was: Parked <input type="checkbox"/> Stationary <input type="checkbox"/> Moving <input type="checkbox"/> Speed					
Traffic controls: None <input type="checkbox"/> Stop sign <input type="checkbox"/> Traffic Lights <input type="checkbox"/> Roundabout <input type="checkbox"/> Give way sign <input type="checkbox"/> Other <input type="checkbox"/>					
Number of other vehicles involved					
If applicable, what type of goods were being transported at time of loss?					
What happened?					
Who was at fault?	Surname		Given Name(s)		
SKETCH DIAGRAM OF ACCIDENT					
<p>1. Name streets</p> <p>2. Indicate direction of travel</p> <p>3. Your vehicle <input checked="" type="checkbox"/></p> <p>4. Other vehicle <input type="checkbox"/></p>					

Damage to Your Vehicle			
Are you claiming for the damage to your vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/>			
Was the vehicle towed? No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details			
Name of tow company			
Where was it towed?			Distance towed
Kms			
Where is vehicle now?			
SKETCH DIAGRAM			
<p>Shade in damage to vehicle.</p> <p>Indicate point of impact (X)</p>			
			

Owner of Other Vehicle			
Name		Surname	
		Given Name(s)	
Address			
			State
			Postcode
Contact Numbers	Business	()	Private ()
Insurance Co.			Policy No.

Driver of Other Vehicle					
Name	Surname		Given Name(s)		
Address					
				State	
Contact Numbers	Business	()	Private	()	
Date of Birth	/	/	Driver's Licence Number		
Was the owner in the vehicle at the time of the accident?					No <input type="checkbox"/> Yes <input type="checkbox"/>
IF THERE IS MORE THAN 1 OTHER VEHICLE INVOLVED PLEASE ATTACH DETAILS.					

Other Vehicle					
Registration No.		Year of Manufacture		Make of vehicle	
Model				Colour	

Damage to Other Vehicle	
<p>SKETCH DIAGRAM</p> <p>Shade in damage to vehicle.</p> <p>Indicate point of impact (X)</p>	

Other Parties			
Give details of pedestrians, owners of property or owners of animals involved.			
Name	Surname		Given Name(s)
Address			
			State

Police			
Did a Police Officer attend the accident scene, No <input type="checkbox"/> Yes <input type="checkbox"/> or did you report the incident to the police? No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details			
Name			Rank
Station			
Date of report	/	/	<i>(Please attach a copy of the Police Report.)</i>
Name of person to be charged or cautioned			
Nature of charge or caution			

Witness(es) Details			
Name	Surname		Given Name(s)
Address			
			State
Contact Numbers	Business	()	Private ()
Was this witness in the insured vehicle?			No <input type="checkbox"/> Yes <input type="checkbox"/>
Name	Surname		Given Name(s)
Address			
			State
Contact Numbers	Business	()	Private ()
Was this witness in the insured vehicle?			No <input type="checkbox"/> Yes <input type="checkbox"/>

Owner(s) and Driver History

In the last 5 years have you as owner or the driver of this vehicle:

1. Had an insurance refused, declined or cancelled by an insurer or any special conditions imposed? Yes No
2. Been convicted or charged with:
 - a) Drug use, driving under the influence, or exceeding Prescribed Concentration of Alcohol? Yes No
 - b) Any driving offences or speeding ? Yes No
 - c) Fraud, arson, theft or any other criminal act? Yes No
3. Had a drivers or motorcycle licence cancelled, suspended or endorsed? Yes No
4. Had a claim or accident? Yes No
5. Had a car stolen or burnt out? (include any not reported or not claimed from an insurer) Yes No
6. Suffered or suffer from impaired eyesight (excluding wearing of glasses), loss of or use of any limb or loss of hearing or from any physical defect or epileptic, diabetic, heart or mental condition? Yes No

If you answered "Yes" to any of the above questions please provide relevant details below

Name of Driver	Date of Incident	Details of each Incident	Your Insurer	Person at Fault
e.g. <i>John Smith</i>	<i>Feb 04</i>	<i>Speeding 80km in 60km zone</i>	-	<i>Self</i>
<i>Bill Jones</i>	<i>Apr 05</i>	<i>Hit third party in the rear</i>	<i>QIB Co</i>	<i>Bill</i>

If there is insufficient space, please attached a sheet with the relevant information.

Privacy

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com or contact the Compliance Manager on 02 9375 4656 or email compliance.manager@qbe.com for further information.

Declaration and Authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/We understand the claim may be refused if information is not true or is withheld.
2. I/We authorise QBE Insurance (Australia) Limited to give to and obtain from other insurers, insurance reference 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.

Date

Signature of Insured 2.

Date

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

Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4229, Sydney NSW 2001.