



MOTOR VEHICLE ACCIDENT Claim Report



HBA General Insurance and Mutual Community General Insurance
Insurer: Mutual Community General Insurance Pty Ltd
ABN 59 007 895 543

Please retain this page for your information

ABOUT YOUR CLAIM

- If you take your vehicle to one of our approved repairers no other quotations will be required. Our approved repairers have a supply of our claim forms.
- For most claims we will check the damage and have repairs authorised and paid for.
- In certain circumstances, we may request a second quotation be obtained.
- If someone else involved in the accident contacts you about a claim, or for information, refer the person to our office.
- If you receive a writ or summons, or anything else from a legal firm, forward it to us immediately.
- We need to handle everything related to your claim.
- Please refer to your policy booklet for more information about how your claim will be handled.
- We may need to get a police report.
- If you have any questions about your claim, please contact our Claims Department:

HBA General Insurance
GPO Box 2176T, Melbourne VIC 3001
Tel: 1800 106 951 Fax: 1300 300 094

Mutual Community General Insurance
PO Box 312, Rundle Mall SA 5000
Tel: 1800 182 289 Fax: 1300 300 094

HOW YOU CAN RESOLVE A DISPUTE WITH US

Our dispute resolution system is free and works like this:

1. Please advise the staff at your relevant office (phone number above) if you are dissatisfied with:
 - our decision on your claim,
 - our handling of your claim,
 - the services of our loss adjuster or investigator.
2. The staff member will try to resolve the problem.
3. If unable to resolve it, the staff member will refer it to the supervisor or manager, for immediate attention.
4. If this fails to resolve your problem, you may request that the problem be referred to a Dispute Resolution Officer. This Officer will investigate the dispute and try to reach a satisfactory outcome with you, normally within 21 days of the date you requested the service of a Dispute Resolution Officer.
5. If you do not accept our decision, you may take the problem to the **Insurance Ombudsman Service** (formerly Insurance Enquiries and Complaints), for an independent investigation. The Service can assist with private consumer and some small business type claims.

The telephone number for the **Insurance Ombudsman Service** is **1300 780 808**.

More detailed information about this process is available from our HBA or Mutual Community General Insurance offices.

Insured vehicle details (cont'd)

8. Was there any unrepaired damage to the vehicle before the accident?

No Yes Describe the unrepaired damage

9. What were you using the vehicle for at the time of the accident? (e.g. travelling to work, shopping, business use)

Accident details

10. When did the accident happen?

Date / / Time a.m.
 p.m.

11. Where did the accident happen? Please also provide a street directory map reference if possible.

12. How did the accident happen?

Describe in detail the circumstances leading up to the accident and how the accident happened. It is important to be as accurate as you can. **Please tell us all the facts, even if they are not in your favour.** Tell us which driver you feel is at fault and why.

13. Was a trailer being towed at the time of the accident? No Yes Type of trailer Registration number

14. Did the accident happen at, or near:

(a) Traffic lights? No Yes Indicate the colour of the traffic light facing the:
Insured driver - Red Amber Green
Other driver - Red Amber Green

(b) Stop or Give Way sign? No Yes Indicate the type of sign facing the:
Insured driver - Stop sign Give Way sign
Other driver - Stop sign Give Way sign

15. What were the road conditions at the time of the accident?

(a) Sealed roadway Wet Dry (b) Unsealed roadway Wet Dry

What were the weather conditions at the time of the accident?

Fine Overcast Raining Storm Hail Other weather conditions

What vehicle lights were in use?

What signals were given?

By you By the other driver By you By the other driver

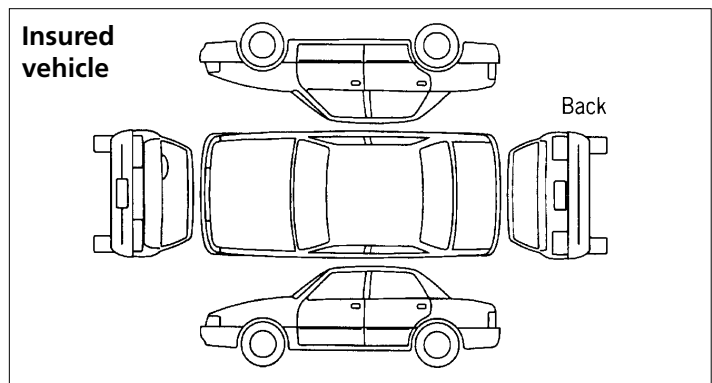
16. At the time of the accident what was the approximate speed **before braking** of the:

(a) Insured vehicle km/h (b) Other vehicle km/h

17. Using the symbols below draw a diagram of the accident scene showing the position of all vehicles. Indicate by arrows the direction in which the vehicles were travelling, the names of the streets and the north point of the compass. Please identify any other vehicles involved as '2', '3', '4' etc. It is important that the sketch be as accurate and as detailed as possible as it may be used in legal proceedings.

Your vehicle 	Other vehicle 	Pedestrian, Cyclist etc. 	Road 	Stop sign 	Give way sign 	Lights 

18. On this diagram please shade the areas damaged in the accident.



19. If we wish to inspect the vehicle, whom do we contact and where will the vehicle be?

Name of person	Telephone no.
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>
Address where the vehicle is being kept	
<input style="width: 98%;" type="text"/>	
	Postcode
<input style="width: 98%;" type="text"/>	

20. Was your vehicle towed from the scene of the accident? Yes No

Driver details

21. Who was driving the vehicle when the accident happened?

<input style="width: 98%;" type="text"/>			
Relationship to insured (e.g. son, daughter, employee)			
<input style="width: 98%;" type="text"/>			
Address			
<input style="width: 98%;" type="text"/>			
	Postcode		
Private telephone no.	Business telephone no.	Facsimile no.	Mobile
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>

Was this person driving with the knowledge and consent of the insured?

No Yes

22. Did the driver have a current driver's licence for this class of vehicle?

No <input type="checkbox"/> Yes <input type="checkbox"/>	Licence no.		
	<input style="width: 90%;" type="text"/>	Learner's <input type="checkbox"/>	'P' plates <input type="checkbox"/>
		Full <input type="checkbox"/>	
Years licenced	Date of birth	List any restrictions on the licence	
<input style="width: 90%;" type="text"/>	<input style="width: 90%;" type="text"/>	<input style="width: 98%;" type="text"/>	

Driver details (cont'd)

23. Did the driver drink any alcohol, or take any drugs or medication in the 12 hours prior to the accident?

No

Yes

What did the driver drink or what drugs or medication did the driver take?

When?

How much?

24. Has the driver been charged with or convicted of a motoring offence (other than a parking offence) or been disqualified from driving in the past 5 years?

No

Yes

State the details

25. Has the driver been charged with, or convicted of, any criminal offences in the past 10 years?

No

Yes

State the reasons

26. Has the driver had insurance refused or cancelled, had a renewal refused or had special conditions imposed by an insurer?

No

Yes

State the reasons

27. Has the driver been involved in a car accident, or claimed against an insurance company for fire, theft or damage to a car, in the past 5 years?

No

Yes

Complete details below

Full name of person

Date of occurrence

Brief details (e.g. hit other car in rear)

Your insurance company's name

Was a claim submitted to your insurance company? No

Yes

Other vehicle(s) details

Please provide information about the other vehicle(s), even if they were not damaged. This will help in our investigation. If additional vehicles were involved, attach details of those vehicles on a separate sheet.

28. Owner's details (Vehicle 2)

Full name

Telephone no.

Address

Postcode

Owner's insurance company

Make, model, body type and colour

Registration number

Year of manufacture

Driver's details (Vehicle 2)

Full name

Telephone no.

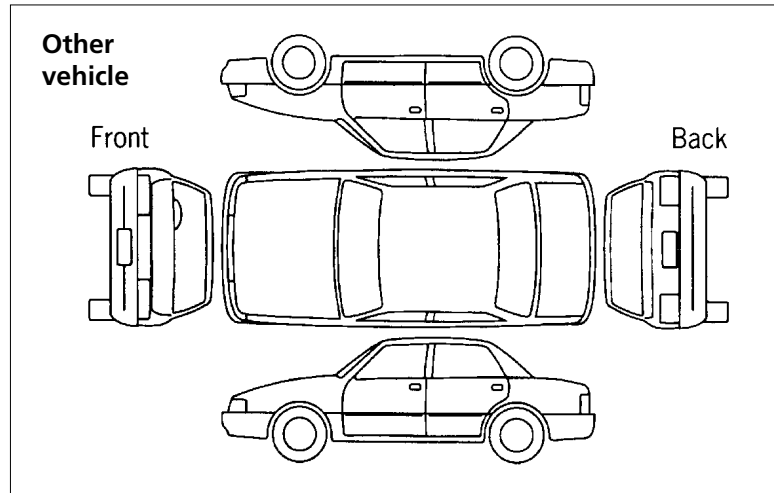
Address

Postcode

Licence number of driver

Date of birth

29. Please shade the damaged areas of the **other** vehicle(s) damaged in the accident



30. As a result of the accident, was there any other property damaged (e.g. fences, telephone poles)?

No

Yes

Provide details (including name and address of owner)

31. Were there any witnesses to the accident?

No

Yes

Please complete the details below

Witness No. 1

Full name

Telephone no.

Address

Postcode

Type of witness: Passenger in — insured's vehicle — other vehicle Independent eye witness

Witness No. 2

Full name

Telephone no.

Address

Postcode

Type of witness: Passenger in — insured's vehicle — other vehicle Independent eye witness

List other people on a separate page and attach the page to this form.

32. Did the police or fire brigade attend the accident?

No Yes Police OR Fire Brigade

Officer's name

Name of station

33. Was the accident reported to a police station?

No Yes Officer's name

Name of station

Date reported

Police report no.

34. Was either driver asked to take a Breathalyser test?

No Yes Insured driver the result %

Other driver the result %

35. Was either driver subjected to a blood test?

No Yes Insured driver the result % (Your certificate is required)

Other driver the result %

36. Was either driver charged with an offence or offences or advised that charges may be laid?

No Yes Insured driver and the offence(s)

Other driver and the offence(s)

Declaration

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

I consent to Mutual Community General Insurance Pty Ltd using my personal information I have provided on this form for the purpose of processing my claim. I understand that if I choose not to provide the required details, this is my choice, however, Mutual Community General Insurance Pty Ltd may not be able to process my claim.

* I consent to Mutual Community General Insurance Pty Ltd disclosing my personal information to other insurers, an insurance reference service or as required by law. I consent to Mutual Community General Insurance Pty Ltd also disclosing my personal information to and/or collecting additional information about me, from investigator, legal advisors, other insurers, police department or any other state government department.

Signature of the insured or person with authority to sign for and on behalf of a company or partnership

Date

Signature of the driver (if not the insured)

Date

* This consent only applies when a claim is submitted in relation to a policy issued to the individual, not a company or business.

Please indicate the number of additional pages attached to this claim report

When complete, please forward the report to your relevant office:

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