THE INSURANCE COMPANY OF THE WEST INDIES LIMITED
Unit 6, Independence Business Park, East Street South, P. O. Box SS-19023, Nassau, Bahamas
Tel: (242) 323-4004, Fax: (242) 322-6715

MOTOR VEHICLE CATASTROPHE CLAIM FORM

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made.

NOTE: "N/A" means "Not Applicable"

Insured's Signature ______________________

THE INSURED

Name: ______________________

Address: ______________________

Cell Phone: ____________ Home Phone: ____________ Work Phone: ____________

Fax: ____________ Email Address: ____________

PARTICULARS OF VEHICLE

Year: ________ Make: ________ Model/Type: ________ Policy No.: ________

Colour: ________ Registration No.: ________ Value: $ ________

Mortgage Interest and Address: ______________________

THE INCIDENT

Date of Loss: ____________ Is the vehicle driveable? ◯ YES ◯ NO

Extent of Damage (briefly describe the damage that appears to have been sustained by the vehicle): ______________________

Location of vehicle: ______________________

I/We hereby declare that the foregoing particulars given by me/us have been read over and found to be true and correct in every respect, and I/we agree that if I/we have made, or in any further declaration the Company may require in respect of the said accident shall make, any false or fraudulent statement, or if found guilty of any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or further accidents, shall be forfeited.

Signature of Insured: ______________________ Date: ____________

Signature of person reporting the claim: ______________________ Date: ____________

OFFICE CHECKLIST

Period of Policy: From: ____________ To: ____________

Premium Paid: ◯ YES ◯ NO **Comprehensive Cover:** ◯ YES ◯ NO

Assessor Appointed: ◯ YES ◯ NO **Assessor Name** (Please print): ____________

Name of Broker/Agent: ______________________

Claim Number: ______________________

Remarks: ______________________