



# 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

## MOTOR THEFT CLAIM FORM

### THE INSURED

"N/A" means "Not Applicable"

Name: \_\_\_\_\_ Contact #s: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer/Business Name: \_\_\_\_\_  
 Employer/Business Address: \_\_\_\_\_  
 Contact #s: \_\_\_\_\_ Email Address: \_\_\_\_\_

### VEHICLE INFORMATION

Policy #: \_\_\_\_\_ Year: \_\_\_\_\_ Make: \_\_\_\_\_  
 Reg. #: \_\_\_\_\_ Colour: \_\_\_\_\_ Model/Type: \_\_\_\_\_  
 Was there any unrepaired damage prior to the theft?  Y  N If so, give details: \_\_\_\_\_  
 Were there any modifications?  Y  N If so, give details: \_\_\_\_\_  
 Distinguishing marks?  Y  N If so, give details: \_\_\_\_\_  
 Special fittings and accessories?  Y  N If so, please state: \_\_\_\_\_  
 Has the vehicle been recovered?  Y  N If so, in what condition: \_\_\_\_\_  
 Where can the vehicle be inspected? \_\_\_\_\_  
 Name and Address of any Bank or Company financially interested in the vehicle: \_\_\_\_\_

### USE OF VEHICLE

State the exact purpose for which the vehicle was being used at the time of the theft: \_\_\_\_\_  
 Were goods being carried?  Y  N If yes, state the nature of the goods: \_\_\_\_\_ and weight of load: \_\_\_\_\_  
 How many persons including the driver were in the vehicle? \_\_\_\_\_ Were they charged a fee to be transported?  Y  N  
 If the vehicle was driven by a person other than the Insured, with whose permission was it being used? \_\_\_\_\_  
 Was the Insured in the vehicle when the theft occurred?  Y  N

### THE THEFT

Date of theft: \_\_\_\_\_ Time: \_\_\_\_\_ Place: \_\_\_\_\_  
 Was it a hold up?  Y  N Would you be able to identify the person or persons?  Y  N  
 If yes, please state: \_\_\_\_\_  
 Were there any Witnesses?  Y  N If yes, please give information below:  
 Witness #1 Name: \_\_\_\_\_ Witness #1 Contact #: \_\_\_\_\_  
 Witness #2 Name: \_\_\_\_\_ Witness #2 Contact #: \_\_\_\_\_  
 Name of Policeman: \_\_\_\_\_ Badge #: \_\_\_\_\_  
 The Station concerned: \_\_\_\_\_  
 Date Reported: \_\_\_\_\_ Time: \_\_\_\_\_

If claim is for loss of parts, tyres, etc., please complete the following:

Description of Items	Price Paid	Where Purchased	Date Purchased	Amount Being Claimed

THE DRIVER  or CUSTODEE  (Please select appropriate box)

Name: \_\_\_\_\_ Contact #s: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer/Business Name: \_\_\_\_\_  
 Driver's Licence Number: \_\_\_\_\_ Date issued: \_\_\_\_\_ Driving experience: \_\_\_\_\_  
 Type of Licence: \_\_\_\_\_ Previous Accidents: \_\_\_\_\_  
 What is the relationship between the Insured and the Driver? \_\_\_\_\_

