



# THE INSURANCE COMPANY OF THE WEST INDIES (CAYMAN) LIMITED

150 Smith Road, P. O. Box 461, Grand Cayman KY1-1106, Cayman Islands, Tel: (345) 949-6970, Fax: (345) 949-6929

## MOTOR VEHICLE 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..... Mr/Mrs/Miss: Date of Birth: .....

Address ..... Phone: .....

Business/Profession: ..... Employer .....

Business Address ..... Phone .....

Email Address .....

### THE POLICY

Type of Policy ..... Policy No. .... Period of Cover ..... Excess % .....

Type of Cover ..... Insured Value ..... Restrictions .....

State whether or not a Valuation/Inspection was done at renewal/inception. If yes, by whom? .....

### PARTICULARS OF VEHICLE

Year ..... Make ..... Model/Type ..... Regn. No. ....

Colour ..... Condition of Tyres ..... Was there any unrepaired damage prior to the accident? .....

If so, give details .....

Name and Address of any Bank or Company financially interested in the vehicle? .....

Type of Road Licence: i.e. whether Private, Private C.M.C., Public C.M.C. or P.P.V. ....

Were any trailers attached to the vehicle? If so, give description and weight of load .....

If a Motor Cycle, was a Pillion Rider carried? .....

### PARTICULARS OF USE

State specifically the purpose for which the vehicle was being used at the time of the accident .....

Were goods being carried? ..... If so, state the nature of the goods and weight of the load .....

How many persons including the driver were in the vehicle? ..... Were they charged a fee to be transported? .....

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 accident occurred? .....

### THE DRIVER

Name ..... Mr/Mrs/Miss Date of Birth .....

Address ..... Phone .....

Occupation ..... Employer ..... Driving Experience .....

Driver's Licence No. .... Date Issued ..... Which Tax Office? .....

Type of Licence: PVT, GEN, GEN to include PPV. /Foreign Country ..... How many accidents in the last 3 years? .....

What is the relationship between the Insured and Driver? .....

Has driver ever been convicted for a Motor Vehicle offence? ..... If so, what? .....

Had driver been drinking? ..... Has driver ever been refused Insurance? .....

Does driver own a Vehicle? ..... If so, please name Insurance Co. ....

Does the driver suffer from any physical infirmity, defective hearing or vision? .....

### THE ACCIDENT

Date of accident ..... Time ..... Place ..... Parish .....

Who in your opinion was at fault? .....

Did the Police investigate or take particulars? ..... If so, state:-

Name of Policeman ..... Number .....

The Station concerned ..... Were you warned for prosecution? .....

Did the driver of the vehicle (or third party) make any statement bearing on the accident? .....

Did the driver (or third party) of the other vehicle appear to be under the influence of liquor/drugs? .....

Have you received any intimation of a claim from the other driver (or Third Party) .....

Condition of Road ..... Kind of surface ..... Visibility .....

**THE ACCIDENT** (Continued)

	INSURED'S VEHICLE	THIRD PARTY #1	THIRD PARTY #2
Direction of travel?	_____	_____	_____
On which side of the road?	_____	_____	_____
Speed (a) Before accident?	_____	_____	_____
(b) At the time of accident?	_____	_____	_____
Lights (on, off, dim or bright)	_____	_____	_____
Was horn sounded?	_____	_____	_____

**DAMAGE TO INSURED VEHICLE**

Particulars of damage to Insured's vehicle .....

.....

Did a wrecker remove the vehicle? If so, give name and address .....

.....

Where can the vehicle be inspected ..... Phone .....

Repairer's Name and Address ..... Estimate \$.....

**PARTICULARS OF PASSENGERS IN INSURED'S VEHICLE**

NAME	ADDRESS	OCCUPATION	AGE	RELATIONSHIP WITH THE INSURED	NAME OF INJURY, IF ANY AND HOSPITAL ATTENDED

**WITNESSES**

Independent Witnesses (Not previously known to Insured)	Name .....	Address .....	Phone .....
	Name .....	Address .....	Phone .....
	Name .....	Address .....	Phone .....
	Name .....	Address .....	Phone .....
	Name .....	Address .....	Phone .....
Other Witnesses	Name .....	Address .....	Phone .....
	Name .....	Address .....	Phone .....

**PARTICULARS OF THIRD PARTIES**

IF PEDESTRIAN OR CYCLIST, PLEASE STATE:-

(a) name and address ..... phone .....

(b) nature of injury, if any .....

(c) damage to cycle .....

IF VEHICLE, PLEASE STATE:-

1. Owner's name and address ..... Phone .....

2. Driver's name and address .....Phone .....

3. Year ..... Make ..... Model ..... Regn. No. ....

4. How many passengers were in the vehicle? ..... How many were injured? .....

5. Insurance Company ..... Nature of damage .....

..... Approximate cost of repairs \$ .....

1. Owner's name and address ..... Phone .....

2. Driver's name and address .....Phone .....

3. Year ..... Make ..... Model ..... Regn. No. ....

4. How many passengers were in the vehicle? ..... How many were injured? .....

5. Insurance Company ..... Nature of damage .....

..... Approximate cost of repairs \$ .....

Please give details below of passengers injured in Third Party's vehicle:

NAME AND ADDRESS	OCCUPATION	APPROX. AGE	INJURY IF ANY



