



**THE INSURANCE COMPANY OF THE WEST INDIES LIMITED**

2 St. Lucia Avenue, Kingston 5. Tel: (876) 926-9040-7. Email: direct@icwi.com

**MOTOR VEHICLE CATASTROPHE CLAIM FORM**

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

**THE INSURED**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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: \_\_\_\_\_

**OFFICE CHECKLIST**

Period of Policy: From: \_\_\_\_\_ To: \_\_\_\_\_

Premium Paid:  YES  NO Comprehensive Cover:  YES  NO

Assessor Appointed:  YES  NO Assessor Name: \_\_\_\_\_

Name of Broker/Agent: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_