



THE INSURANCE COMPANY OF THE WEST INDIES (CAYMAN) LIMITED

1c Bird Rock, Basseterre, St. Kitts & Nevis. Tel.: (869) 465-8753. Email: stkitts@icwi.com

MOTOR THEFT CLAIM FORM

THE INSURED

"N/A" means "Not Applicable"

Name: _____ Contact #: _____
 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 #: _____
 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? _____

