The Insurance Company of the West Indies Limited (Sint Maarten) B.V.

Welfare Road #40B, Cole Bay, St. Maarten, Tel: (721) 544-5074, Fax: (721) 544-5075

DRIVER'S PROPOSAL FORM

IMPORTANT: A DEFINITE ANSWER MUST BE GIVEN TO EACH QUESTION

Driver's Full Name: _____ Date of Birth: _____
DD - MM - YYYY

Private Address: _____

E-mail Address: _____ Tel. # _____

Profession/Trade or Occupation (Describe fully) _____

Name and Address of Employer: _____

Do you currently have a motor vehicle insured elsewhere, or have you previously held a motor vehicle insurance policy?
If yes, please give details below:

(a) Name of Insurance Co. _____ Policy No. _____

(b) Year of Insurance _____ Make and Model of Vehicle _____

Details of Driver's Licence:

(a) Full or Provisional _____

(b) Licence Number _____

(c) Vehicles permitted to drive _____

(d) Issue Date _____ (e) Expiry Date _____

Give details below of any illness or medical condition, whether physical or mental, **including but not limited to** diabetes, hypertension, epilepsy, stroke, heart condition, fainting spells, hallucinations, defective vision or hearing.

_____

_____

In the past five (5) years, have you:
(1) been fined, (2) had your licence endorsed / revoked, (3) been prosecuted for a motoring offence? If yes, please give details below:

Date	Offence

Has any company or underwriter in respect of any Motor Insurance Policy ever:

(a) Declined to insure? _____ (b) Cancelled the insurance? _____ (c) Refused to renew? _____

(d) Required increased premiums, special terms or an excess? _____

If yes, please give details _____

Have you had any accidents or losses during the past three (3) years (whether insured or not) involving vehicles:
(i) owned by you, whether or not you were the driver at the material time?
(ii) not owned by you, but driven by you or in your custody at the material time?
If yes, please give details below:

Year of Accident	Total Number of Vehicles Owned	Total Number of Accident(s)	Particulars of Accident(s)	Particulars of the Vehicle Involved in Accident	Amount Paid

Give names and addresses of persons and/or firms to whom you have been employed as a driver during the past three (3) years.

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

Name of Insured: _____

Relationship to Insured: _____

I warrant that the statements made and particulars given thereon are true.

Signature of Driver: _____ **Date:** _____

FOR INTERNAL PURPOSES ONLY	Name (please print)	Signature	Date
Claims Bank check			
Approved by			

(Revised: 11 March 2019)