THE INSURANCE COMPANY OF THE WEST INDIES (TRINIDAD) LIMITED
13 Gray Street, St. Clair, Trinidad. Tel.: (868) 625-1116-9. Email: trinidad@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:	

(Revised Jun-2022)