



# 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 THEFT CLAIM FORM

### THE INSURED

"N/A" means "Not Applicable"

Name: _____	Contact #s: _____
Home Address: _____	
Occupation: _____	Email Address: _____
Employer/Business Name: _____	Contact #s: _____
Employer/Business Address: _____	

### VEHICLE INFORMATION

Policy #: _____	Year: _____	Make: _____
Reg. #: _____	Colour: _____	Model/Type: _____
Was there any unrepaired damage prior to the theft? <input type="checkbox"/> Y <input type="checkbox"/> N If so, give details: _____		
Were there any modifications? <input type="checkbox"/> Y <input type="checkbox"/> N If so, give details: _____		
Distinguishing marks? <input type="checkbox"/> Y <input type="checkbox"/> N If so, give details: _____		
Special fittings and accessories? <input type="checkbox"/> Y <input type="checkbox"/> N If so, please state: _____		
Has the vehicle been recovered? <input type="checkbox"/> Y <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N	

### THE THEFT

Date of theft: _____	Time: _____	Place: _____
Was it a hold up? <input type="checkbox"/> Y <input type="checkbox"/> N	Would you be able to identify the person or persons? <input type="checkbox"/> Y <input type="checkbox"/> N	
If yes, please state: _____		
Were there any Witnesses? <input type="checkbox"/> Y <input type="checkbox"/> 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 #s: _____
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? _____	

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. Further, I/We agree that, if I/We have made, or in any further declaration the Company may require in respect of the said theft 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 future losses shall be forfeited.

Date: \_\_\_\_\_

Insured's  
Signature:

Driver's  
Signature:

Witness' Name:

Witness' Signature: \_\_\_\_\_