MOTOR ACCIDENT CLAIM FORM

OLD MUTUAL GENERAL INSURANCE KENYA LIMITED
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1. No Liability Is admitted by Issue of this form or by communication of our (Insurers) Claim number subsequently
2. Neither owner nor driver may admit fault or Liability for this Accident.
3. Do not answer communications about this Accident. Direct these to the Insurance Company for Action
4. Please let us have an estimate of repair cost (if available) submitted together with this form
5. All repairs must not be authorized without first reporting of the accident to the Insurance Company

To help us deal with your claim as quickly as possible PLEASE ANSWER ALL QUESTIONS ON THE CLAIM FORM FULLY AND CLEARLY, and sign and date the form.

SECTION A

POLICY DETAILS

Branch: _____ Agent: _____ Policy No.: _____

Date of payment of last premium: _____ Period of Insurance e; From: _____ To: _____

Type of cover: Comprehensive _____ TPF&T _____ TPO _____

Name of hire purchase or finance company (if any):_____

Is there any other insurance in force upon the vehicle? _____

If so, please supply details _____

Did you purchase a loan repayment cover? (Yes/No). Total Principal Loan amount _____ Total Interest, _____

If yes, indicate the monthly instalment: Monthly Principal Repayment _____ Monthly Interest Charged _____

INDIVIDUAL INSURED'S PERSONAL DETAILS (*To be completed where the insured is an individual*)

Surname:_____ Middle Name: _____ First Name: _____

ID No/Passport No.: _____ Nationality: _____ Date of Birth: _____

PIN No: _____ Occupation:. _____

Telephone : Residential _____ Telephone: Office _____ Mobile _____

Postal Address: _____ Postal Code _____

Physical address: _____ _____

Email:_____

Trade/business of Insured:_____

Age Band (individuals) ☐ 1 Byrs-21 yrs ☐ 22yrs-40yrs ☐ 41 yrs-69yrs ☐ Above 70 years

CO PRORATE INSURED'S DETAILS *(To be completed where the insured 1s a registered business)*

Company Registered name: _____

Registration No.: _____ Country of Registration _____

PIN No: _____VAT Registration No.: _____

__Telephone: Office Line _____ Mobile (Contact Person) _____

Postal Address: _____ Postal Code _____

Physical address of registered office _____

Email : _____Trade/business of Insured_____

How long has the company been in operation? ☐ 0yrs - 1 yrs ☐ 2yrs - 3yrs ☐ 3 yrs - 5yrs ☐ Over 5 yrs

SECTION B

VEHICLE DETAILS

Make _____ Model: _____ Year of manufacture _____

Reg. No. {Prime Mover/Truck)_____Carrying capacity (Cabin)_____Loading Capacity _____

Reg. No. (Trailer) _____ Loading Capacity _____

Name and Address of Registered Owner _____

Vehicle Use: State the EXACT PURPOSE for which the vehicle was being used at the time of the accident

(***e.g. was carrying bags of cement… etc.***)

_____

_____

_____

ACCIDENT DETAILS *(Please provide as much information as possible to aid in faster decision making)*

Date' _____ Time: (a.m./p.m.) _____

Place _____ Type of Road surface _____

Visibility _____ Weather Condition: Wet or Dry? _____

What warning did your driver give? _____

What lights were showing on your vehicle? _____

Did Police take particulars? _____

If so, give Constable's number and station _____

Attach copy Notice of Intended prosecution If any: _____

SKETCH PLAN OF VEHICLE(S) AT THE ACCIDENT SCENE *(You can attach the sketch on a separate sheet)*

STATEMENT BY DRIVER *(if the below space is not enough, attach a detailed statement on a separate sheet)*

_____

_____

_____

_____

_____

_____

_____

Name_____Signature. _____Date_ _____

SECTION C

DAMAGE TO INSURED VEHICLE

State briefly apparent

damage_____

_____

_____

When and where can it be inspected? _____

Repairer's name and address _____ _____ Tel No _____

Is the vehicle still in use? {Yes/No) _____ _____ _____

(IN ALL CASES WHERE YOUR VEHICLE IS DAMAGED AND YOU ARE ENTITLED TO CLAIM UNDER YOUR POLICY, PLEASE SEND AT ONCE TO THE COMPANY AN ESTIMATE FOR REPAIRS).

DAMAGE TO GOODS CARRIED

Description of goods being carried _____ _____ _____

Name of owner of goods _____ _____ _____

Was a trailer attached? _____ _____ _____

Weight of load on

(a) Vehicle _____ (b) Trailer(s) _____

OTHER VEHICLES INVOLVED

Name and address of owner	Reg. No.	Name of Insurer

DAMAGE TO THIRD PARTY PROPERTY

Name and address of owner	Property damaged

PERSONS INJURED

Name and address	Relationship to the insured	If driver or passenger,	Apparent injuries
		Reg. No. of vehicle	

PASSENGERS IN YOUR VEHICLE

Name _____ _____ Address _____

Name _____ _____ Address _____

Name _____ _____ Address _____

INDEPENDENT WITNESSES

Name _____ _____ Address_____

Name _____ _____ Address _____

Name _____ _____ Address _____

SECTION D:

This section to be completed by the owner /insured

DRIVERS' DETAILS (even if the insured)

Name _____ _____ _____ _____

Occupation _____ _____ Date of birth _____

Address _____ _____ _ Tel No. _____

Is he/she employed by you? Yes ☐ No ☐

How long has he/ she been in your service? _____

Was he/she driving with your permission? Yes ☐ No ☐

How long has he/ she been driving motor vehicles? _____

Was he/ she in any way to blame for the accident? Yes ☐ No ☐

Did he/she admit liability? Yes ☐ No ☐

Did he/ she had any previous accidents? Yes ☐ No ☐

If so, how many, an approximate date? _____

Has he any conviction for any offence in connection with any motor vehicle or any charges pending? Yes ☐ No ☐

If so, give details including dates _____

_____

Does he/she hold a full or provisional licence to drive this vehicle? Yes ☐ No ☐

Full D Provisional D If full, state date when driving test first passed _____ Driver' Licence Number _____

Does he/ she own a Motor Vehicle? Yes ☐ No ☐

If so, give name and address of Insurer _____

Driver's Policy No. _____

STATEMENT BY OWNER/INSURED *(if the below space is not enough, attach a detailed statement on a separate sheet)*

_____

_____

_____

_____

Declaration by Owner/Insured

I/We declare that all the answers are true and complete to the best of my/ our knowledge.
I/We hereby claim for the loss or damage as set out above.

Name, _____ ***Signature*** _____

Title _____ ***Date*** _____

COMPANY STAMP