

Motor Vehicle Claim Form

N.B. This form must be completed by the driver.

Please answer all questions. If not applicable, please write N/A



Lumley General Insurance (NZ) Ltd (Insurers) acting through their agent

International Underwriting Agencies Ltd ("IUA") PO Box 7238, Wellesley Street, Auckland 1141

Pursuant to the Privacy Act 1993 the following is brought to your attention:

- (a) This claim form collects personal information about you;
- (b) The information is collected to evaluate your claim;
- (c) The intended recipient of the information is: The Insurers named above (herein-after called "the Company") and is being held by them or by their agent IUA;

- (d) The collection of this information is required pursuant to the terms of your insurance policy;
- (e) The failure to provide this information may result in your claim being declined;
- (f) You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993.

Due Date:

Excess:

Premium Paid: ☐ Yes ☐ No

1. POLICY HOLDER

Surname of Insured
OR Name of Company:

First Names of Insured:

Address:

Telephone: Home:
Business:

Email:

Name of any other party with
financial interest in the vehicle:

Is there any other insurance
on the vehicle or accessories ☐ Yes ☐ No Details:

INSURED VEHICLE

MAKE:

MODEL:

TYPE: (eg. Van, Car, Artic, Flat-top etc.)

YEAR: REGISTRATION
NUMBER:

Has the vehicle been modified in any way:

Is the vehicle a used import? ☐ Yes ☐ No

Has the vehicle a current Certificate of Fitness? ☐ Yes ☐ No

2. PERSON DRIVING OR IN CHARGE OF THE INSURED VEHICLE (to be completed, even if parked)

Title: Surname:

Address:

First Names:

Date of Birth:

Occupation:

Telephone Home: Work:

Drivers License Number: Type: Years Held: Date: Country of Issue:

License Classes (Please list): License Special Conditions (Please list):

1. Was the vehicle being driven with the owner's consent? ☐ Yes ☐ No If No please provide details:

2. Is he/she the main driver of the Insured vehicle? ☐ Yes ☐ No

3. If not the Policyholder do you own a vehicle? (name of insurance co) ☐ Yes ☐ No If Yes please provide details:

4. Did driver consume liquor and/or drugs (include medication) with in 24 hours prior to the accident? ☐ Yes ☐ No

5. Did the Police attend? ☐ Yes ☐ No

6. Have the police laid or mentioned laying charges against the driver of the vehicle? ☐ Yes ☐ No If Yes do you know what the charges are likely to be?

7. Was a breathalyzer, or blood test, or any other such test done? ☐ Yes ☐ No

8. During the past 5 years, have you:
(i) been convicted of any offence other than parking? ☐ Yes ☐ No If Yes please state type and penalty:

(ii) had any other accident, loss of claim in connection with any motor vehicle? ☐ Yes ☐ No If Yes please brief details of year/cost/insurance:

3. DETAILS OF OTHER PERSONS

| Passengers in your vehicle | Independent witnesses |
|---|---------------------------------|
| Name: | Name: |
| Address: | Address: |
| Telephone: | Telephone: |
| Name: | Name: |
| Address: | Address: |
| Telephone: | Telephone: |
| Owner/Driver of other vehicle or property | |
| Name: | Name: |
| Address: | Address: |
| Telephone: | Telephone: |
| Vehicle/Property Details: | Vehicle/Property Details: |
| Registration No.: Insurance Co: | Registration No.: Insurance Co: |

4. DETAILS OF LOSS OR ACCIDENT (Please continue on a separate sheet if necessary)

| | | |
|---------------------------------------|--|---|
| Date: | Time: | am pm (delete one) |
| Location (eg. street): | Suburb or Town: | |
| Weather: | Rain <input type="checkbox"/> | Overcast <input type="checkbox"/> |
| | Fog <input type="checkbox"/> | Bright Sun <input type="checkbox"/> |
| | Clear Night <input type="checkbox"/> | |
| Road: | Sealed <input type="checkbox"/> | Metal <input type="checkbox"/> |
| | Wet <input type="checkbox"/> | Dry <input type="checkbox"/> |
| What speed limit was in force? | 50km/hr <input type="checkbox"/> | 100km/hr <input type="checkbox"/> |
| | Other <input type="checkbox"/> | Please state: |
| What was your speed prior to braking? | At impact? | |
| Please state reason for journey: | | |
| Did anyone get hurt in the accident? | Yes <input type="checkbox"/> No <input type="checkbox"/> | If Yes please advise who and their relationship to the driver and known extent of the injuries: |

Describe in detail how the accident occurred:

What, in your opinion, caused the accident:

5. DAMAGE TO INSURED VEHICLE (NB: Do not proceed with repairs without IUA's authority)

| | | |
|----------------------------------|------------------------------------|-----------|
| Describe Damage: | | |
| Repairer: | Telephone: | Estimate: |
| If not at above, date of repair: | OR where can vehicle be inspected? | |

6. SKETCH PLAN OF ACCIDENT (Please continue on a separate sheet, if necessary)

Indicate: Street names; direction of vehicles. Your vehicle  Other vehicle - - - - - 

DECLARATION: Note: Failure to provide full and truthful information could result in the Claim being declined.

- I/We agree to The Company acting through their agent IUA disclosing my/our personal information regarding this claim to:
 - Other parties including other members of the Insurance Industry and the data base of the Insurance Claims Register (ICR Ltd) P.O. Box 474, Wellington, where it will be retained and made available to other insurance companies to inspect.
 - Parties who have a financial interest in the subject matter of the policy and parties repairing or replacing the subject matter of the claim.
 - I/We understand that I am/We are entitled to have certain rights of access to and correction of the personal information held by The Company and ICR Ltd.
- I/We agree to The Company obtaining personal information about me/us that is, in the Company's view, relevant to this claim.
 - From any other party including other members of the Insurance Industry and from Insurance Claims Register Ltd (ICR Ltd) which holds details of claims made by me/us under policies with other insurers.

All the information and answers (whether written or oral) given to The Company in connection with this claim are correct and that no information relevant to the claim has been omitted. I/We authorize The Company to act on my/our behalf.

Policyholder's signature _____ (If a company, state capacity) Date: _____

Driver's signature _____ Date: _____