

MOTOR VEHICLE LOSS OR DAMAGE

CLEAR FORM

PRINT FORM

Claim Form

INSURED

Name of insured	
Policy number	
Contact person	
Contact phone number	
Contact email address	
VAT number	

INCIDENT

Incident type		Was the driver tested for alcohol or drug abuse? (where applicable)	
Date & time of incident			
Date & time discovered		If the driver was tested for alcohol/drug abuse is the report attached?	
Date & time reported			
Place of loss		Is the incident covered under any other policy of insurance?	
What purpose was the vehicle used for			
Speed at impact (where applicable)			
Weather/visibility			

POLICE

Place where reported	
Date of reporting	
Case number (if reported)	

VEHICLE DETAILS

Make	
Model	
Year	
Registration number	
VIN number	
Chassis number	
Kilometers completed	
Details of outstanding finance	
Security fitments (immobilizer / tracking devices)	

FULL DETAILS OF DRIVER

Full name

ID / passport number

Occupation

Was the driver using the vehicle with the insured's permission

Does the driver have any disabilities including eyesight deficiency?

Description of disability

WITNESSES

Witness 1

Name

Contact number

Address

WITNESSES

Witness 2

Name

Contact number

Address

SKETCH OF EVENTS RESULTING IN LOSS OR DAMAGE

DESCRIPTION OF EVENTS RESULTING IN LOSS OR DAMAGE

INJURIES - INSURED VEHICLE OCCUPANTS

CONTACT DETAILS OF INJURED PERSON

Name	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Description	<input type="text"/>

MMF Accident form attached?	<input type="text"/>
MMF Accident form submitted within 14 days of accident?	<input type="text"/>
Are the injured occupants of the insured vehicle employees of the insured?	<input type="text"/>
If the injured occupants of the insured vehicle was employees of the insured, what was the purpose of the trip?	<input type="text"/>

DESCRIPTION OF PERSONAL INJURIES TO OCCUPANTS OF INSURED VEHICLE

Name	<input type="text"/>
Contact person	<input type="text"/>
Contact phone number	<input type="text"/>
Contact email address	<input type="text"/>
Full description of injuries	<input type="text"/>

THIRD PARTY DETAILS

CONTACT DETAILS OF THIRD PARTY

Name	
Contact person	
Contact phone number	
Contact email address	
Insurer details	
Policy number	

VEHICLE DETAILS

Make	
Model	
Year	
Registration number	
VIN number	
Chassis number	
Details of damage to third party vehicle	

DESCRIPTION OF PERSONAL INJURIES TO OCCUPANTS OF THIRD PARTY VEHICLE

Name	
Contact person	
Contact phone number	
Contact email address	
Full description of injuries	

DECLARATION

I / we declare that to the best of my / our knowledge the above statements are true. I acknowledge that the information set out above is provided freely so that Western may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Western may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim, and take all necessary steps ancillary thereto to give effect hereto. I understand that I may be liable for output VAT in terms of section 8(8) of the VAT Act 89 of 1991.

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Insured's signature

Capacity

Date

Cape Town

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E info@westnat.com

Gauteng

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F 012 523 0909
E info@westnat.com

Windhoek

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