

MOTOR ACCIDENT CLAIM FORM

INSURED	Insurer		Policy No.	
	Name			
	Occupation		Telephone No	
	Address			

VEHICLE	Make:	Tare:	Model:
	Gross Vehicle Mass:	Odometer Reading:	
	Registration No:	Value:	
	Date of purchase: / /	Purchase price:	
	If vehicle is subject to a Hire Purchase, Credit or Leasing Agreement, state name and address of Finance Company:		

DAMAGE	Damage to own vehicle	
	Estimate for repairs or attach quote	
	Repairers name address and telephone number	
	Where can your damaged vehicle be inspected?	

DRIVER	Full Name:		Date of Birth:			
	Address:					
	Occupation:		Tel No.			
	Drivers Licence:	No:	Date: / /	Code:		
		Place:		Full Licence	Learners Licence	
	State fully the purpose for which the vehicle was being used			Private	Business	Both
	Was the vehicle being used with your permission?			Yes	No	
	Was the driver in your employ?			Yes	No	
	Has the driver any motor insurance?			Yes	No	
	If YES, please state:	Policy No:	Insurer:			
	Details of any convictions for motoring offences:					
	Has licence been endorsed?			Yes	No	
	Does the driver have any physical defects?			Yes	No	
	Details of previous accidents:					

PASSENGERS (Insured Vehicle)	Details of Passengers in the Insured vehicle	Name	Address	Injury

CPT
0861 682 467 (MUA INS)
PHONE +27 21 525 6200 FAX +27 21 525 6300
ADDRESS Block A & B Edison Square Cnr. Edison
Way & Century Avenue Century City
POSTAL PO Box 84 Century City 7446

DBN
0861 682 467 (MUA INS)
PHONE +27 31 275 8600 FAX +27 31 265 1719
ADDRESS Viewz 11 The Boulevard Westway Office
Park Westville 3630
POSTAL PO Box 2725 Westway 3630

JHB
0861 682 467 (MUA INS)
PHONE +27 11 560 0600 FAX +27 11 327 1710
ADDRESS MUA House 26 Sturdee Avenue
Rosebank Johannesburg 2196
POSTAL PO Box 131152 Bryanston 2021

	For what reason were they being transported?	
	Are they employees?	Yes No

OTHER PARTY DETAILS	Damage to other vehicle	Registration No.	Make / Model	Name & address of owner & driver	Details of damage	
	Damage to property other than vehicles	Name and address of owner			Details of damage	
	Personal Injuries (other than in Insured vehicles)	Name of injured	Relationship to accident e.g. driver, passenger	Details of injuries	Name of hospital (if applicable)	

WITNESSE	Name:		Address:		Telephone No:
THEFT	Date: / /	Time:	Place:		
	Was vehicle locked?	Yes	No		
	Who has the keys?	Yes	No		
	Police Station:	Reference No:			
	Engine No:	Chassis No:	Colour:		
	Details of Accessories stolen:				

ACCIDENT DETAILS	Date: / /	Time:	Place:		
	Speed:	Before accident:	On impact:		
	Weather conditions:		Visibility:		
	Road Surface:		Width of road:		
	Which vehicle lights were on?		Street lighting:		

ACCIDENT DETAILS	Was any warning, e.g. hooting, indication etc. given by you?			
	Police details	Name of Officer:		Police Station:
	Was the driver tested for alcohol or drugs?	Yes	No	Result of test:
	Description of accident:			
Sketch of Accident (if necessary, please use a separate page)	Please show clearly the point of impact and indicate the direction of travel by arrows. Give details of any road safety or warning signs in the vicinity of the scene of accident.			

LICENCE	I have inspected the driver licence and it is free of endorsements / endorsed as shown	
	Signature:	Date: / /

DECLARATION	We hereby declare the foregoing particulars to be true in every respect	
	Signature of driver:	Date: / /
	Signature of owner:	Capacity: Date: / /
	NB. It is important that you notify Insurers immediately you become aware of any impending prosecution, inquest or demand	