



Millennium Underwriting Agencies Pty Ltd  
ABN: 38 079 194 095  
AFSL: 246721

**Adelaide Office**  
176 Fullarton Road Dulwich SA 5065  
PO Box 309 Kent Town SA 5071  
Phone: (08) 8291 2300  
Fax: (08) 8333 0034  
DX: 426

**Sydney Office**  
Level 1, 401 Pacific Highway  
Artarmon NSW 2064  
PO Box 833 Artarmon NSW 1570  
Phone: 1300 789 642  
Fax: 02 9437 9066

## MOTOR VEHICLE CLAIM FORM

### Client Details

Are you registered for GST purposes? Yes  No

What is your ABN? \_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_:\_\_\_\_\_

Have you claimed, or intend to claim an input tax credit on the GST component of the premium applicable to this policy?  
No  Yes  If yes, will you be claiming an amount less than 100%? No  Yes   
If yes, specify amount claimed? \_\_\_\_\_%

Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?  
No  Yes  If yes, will you be claiming and amount less than 100%? No  Yes   
If yes, specify amount claimed? \_\_\_\_\_%

Agent/Broker: \_\_\_\_\_ Due Date: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact Number: Private: \_\_\_\_\_ Business: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_

### Vehicle Details

Make: \_\_\_\_\_ Body Type: \_\_\_\_\_  
Reg. No.: \_\_\_\_\_ Engine No: \_\_\_\_\_  
Year: \_\_\_\_\_

Are you the sole owner?  Yes  No  
If No, state the name and interest of the other party: \_\_\_\_\_  
\_\_\_\_\_

For what purpose was it being used at the time of the accident? \_\_\_\_\_  
\_\_\_\_\_

Was it being used for carriage of fare-paying passengers?  Yes  No  
Was any other insurance in force on it at the time of the accident?  Yes  No

Expiry Date of Registration: \_\_\_\_\_ Name of Registered Driver: \_\_\_\_\_

## Vehicle Details (cont.)

Was a trailer attached?  Yes  No

Description & Weight of Load:

Vehicle: \_\_\_\_\_

Trailer: \_\_\_\_\_

## Driver Details

Name of Driver: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Contact Number: Private: \_\_\_\_\_ Business: \_\_\_\_\_

Licence No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Date & Place first licence issued: \_\_\_\_\_

Special Endorsements: \_\_\_\_\_

Was he/she driving with your consent?  Yes  No

Approx kilometers driven in past year: \_\_\_\_\_

How much alcohol or drugs were consumed by the driver during the 12 hour period before the accident? \_\_\_\_\_

Previous convictions for any driving offence: \_\_\_\_\_

Has the driver previously been refused Motor Insurance or continuance thereof?  Yes  No

Does the driver (not being the insured) own a vehicle?  Yes  No

If so, state name of Company with which it is insured against damage: \_\_\_\_\_

**NB: A COPY OF THE DRIVER'S LICENCE MUST BE ATTACHED**

## Damage

Describe damage to your vehicle directly resulting from the accident: \_\_\_\_\_

Estimated cost of repairs and replacements \$ \_\_\_\_\_ (attach quotation if possible)

Is the vehicle still being used?  Yes  No

At what address can the vehicle be inspected? \_\_\_\_\_

## Other Parties

Other vehicle involved: \_\_\_\_\_ Reg. No.: \_\_\_\_\_

Damage to other vehicle: \_\_\_\_\_

Is the vehicle drivable?  Yes  No Where can it be assessed? \_\_\_\_\_

Drivers Name: \_\_\_\_\_

Drivers Address: \_\_\_\_\_

Owners Name: \_\_\_\_\_

Owners Address: \_\_\_\_\_

Approx Age: \_\_\_\_\_ Licence No: \_\_\_\_\_ Motor Vehicle Insurer: \_\_\_\_\_

## Other Parties (cont.)

Injury or damage to any party/property. (State details of any notice of claim or demand received.)

Name	Address	Nature of injury or damage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any communication received must be forwarded immediately without any indication on liability being given.

## Police

If Police attended, state:

Officers Name/No: \_\_\_\_\_ Police Station: \_\_\_\_\_

Was the driver of the insured vehicle tested for alcohol or drugs?  Yes  No

If so, what was the result: \_\_\_\_\_

If either driver has been charged or may be charged with any offence, please state:

Name: \_\_\_\_\_ Offence: \_\_\_\_\_

## Particulars of Accident

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

Time: \_\_\_\_\_ Date when reported to you? \_\_\_\_\_

Location: \_\_\_\_\_

Type and condition of roadway: \_\_\_\_\_ Approx. width of road: \_\_\_\_\_

Was your vehicle on correct side of road?  Yes  No If so, how far from kerb: \_\_\_\_\_

Was place of accident well lighted?  Yes  No Weather: Fine/raining/foggy: \_\_\_\_\_

Were there any obstructions to visibility?  Yes  No \_\_\_\_\_

Speed immediately before accident? \_\_\_\_\_ Speed at time of impact? \_\_\_\_\_

Did other driver reduce speed?  Yes  No \_\_\_\_\_

What signal was given by you? \_\_\_\_\_ Any by other driver? \_\_\_\_\_

What fault was there by: (a) Your driver? \_\_\_\_\_

(b) Other Party? \_\_\_\_\_

Explain exactly how the accident happened: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: If statement made to Police, please attach a copy.**

## Witnesses

Please give names and addresses. (If none taken, state reasons)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**(It is of the utmost importance to immediately obtain the names and addresses of Witnesses)**

**SKETCH PLAN OF ACCIDENT WITH NAMES OF ROADS AND COURSES OF VEHICLES, AND PERSONS INVOLVED, SHOW ANY OTHER PROPERTY DAMAGE, POSITIONS OF TRAFFIC SIGNS OR SIGNALS AND NORTH POINT.**

Insured Vehicle  Other Vehicle

Insured Vehicle  Other Vehicle

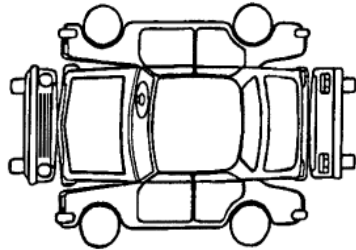
**Positions just before collision**

**Positions at moment of impact**

**SKETCH DIAGRAM**

**Shade in damage to insured vehicle**

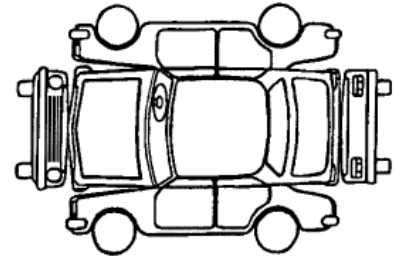
**Indicate point of impact (x)**



**SKETCH DIAGRAM**

**Shade in damage to insured vehicle**

**Indicate point of impact (x)**



## Declaration

I/We hereby declare the foregoing particulars to be true and correct, and I/We undertake to render every assistance in my/our power in dealing with the matter.

Signature of Driver: \_\_\_\_\_

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

Signature of Insured: \_\_\_\_\_

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

**Please check that this form has been fully completed as any omissions may delay your claim.**