# MOTOR VEHICLE CLAIM FORM

(The issue of this form is not an admission of liability)

Trust Name: **JLT (TIAIB) Discretionary Trust 2005/2006**

**JLT Discretionary Trust and Excess of Loss Insurance**

ABN: **070431192**

## MEMBER DETAILS

Name of Member: _____ (insert your Name)

To: **JLT Claims Management, PO Box 7170, Hutt Street SA 5000** **Fax No: (08) 8235 6450**

Business Name (on Membership Pac) _____ Tel No: _____

Mobile: _____

Postal Address: _____

_____ Postcode: _____ Fax No: _____

Are you registered for GST? Yes ☐ No ☐

If YES, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC entitlement) % below.

ABN: _____ ITC% _____ at start of current period of cover

**If you fail to advise the availability of an input tax credit or understate its availability, then you may have a liability to pay tax on the claim payment.**

***IMPORTANT:*** **If more than one named insured is claiming for the loss, please supply details of ABNs and ITC percentages applicable to each entity on a separate page and attach to claim form.**

## ACCIDENT DETAILS

Date of Event: / / Time: _____ am / pm

Address where event occurred: _____ Postcode: _____

Brief Description (including cause of loss or damage) _____

Was the accident your fault? Yes ☐ No ☐

Give reasons: _____

Have you received, or do you anticipate receiving notice of any claim from or on behalf of any Third Parties? Yes ☐ No ☐ If YES, please complete details in appropriate section supplied on this form.

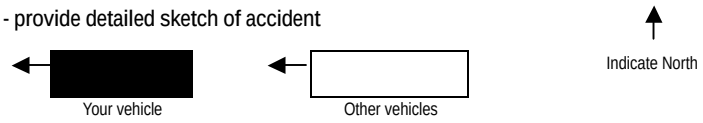
Speed prior to collision _____ kms/hr Estimated speed of other vehicle _____ kms/hr

Mark those conditions which apply to your accident: Wet ☐ Dry ☐

Traffic controls: None ☐ Stop sign ☐ Roundabout ☐ Traffic lights ☐ Give Way Sign ☐ Other ☐

Number of vehicles involved (including own) ☐

Accident plan - provide detailed sketch of accident




## DRIVER DETAILS

Who was the driver at the time of the accident? (Full Name)

Was the driver one of the owners? Yes ☐ No ☐

*Please complete the following details:*

| Address of Driver | Postcode | Date of Birth | Occupation |
|---|---|---|---|
| | | / / | |

Home Ph Number | Work Ph Number:

Mobile Ph Number

Provide Licence details of the Driver

Type of Licence Full ☐ Probationary ☐ Learners ☐

| Licence Number | Class | Expiry Date | Years Held |
|---|---|---|---|
| | | / / | |

Does the driver own a vehicle? Yes ☐ No ☐

If Yes, give details: Vehicle Registration Number | Name of Insurer

In the last 3 yrs has the driver had any accidents or traffic convictions other than parking fines? Yes ☐ No ☐

Give reasons:
(If not sufficient space, attach separate sheet with details)

Was this accident reported to the Police? Yes ☐ No ☐

Did the police attend the accident scene? Yes ☐ No ☐

Police Station: Police report number:

Was alcohol, drugs or medication consumed by the driver in the 8 hours prior to the accident?

Yes ☐ No ☐ If Yes, state quantity:

Was a breathalyser/blood test taken? Yes ☐ No ☐

If Yes, what type? full breathalyser ☐ alco-test ☐ Blood test ☐ What was the reading?

Please note that the analysis statement must be produced

## VEHICLE DETAILS

Give details of YOUR vehicle involved in the accident

| Registration Number: | Year | Make (e.g. Holden) | Model (e.g. Commodore) |
|---|---|---|---|
| | | | |

| Name of Registered Owner | Purchase Date | Price $ |
|---|---|---|
| | / / | |

Is this vehicle covered by your floor plan Insurer? YES ☐ No ☐ ***(Dealership claims only)***

Does any other party have an interest (financial or other) in the vehicle? Yes ☐ No ☐

If Yes, give name and address

What purpose was the vehicle being used for at the time of the accident?

Private ☐ Business ☐ Other

Was YOUR vehicle damaged as a result of this accident

Place "X" on diagram to show areas of damage: Front Rear

Please indicate if you would like us to pay:

Amount Claimed: $ - → the repairer direct (incl. GST) ☐ ***or*** direct to you (Nett of GST) ☐

Was your vehicle driveable after the accident? Yes ☐ No ☐ If NO, give towing and repair details

Towed by: Proposed:

## OTHER PARTIES

If other vehicles were involved in the accident, provide the following details:

| | Surname | Given Names | Address |
|---|---|---|---|
| Registered Owners Details: | | | |

Contact Phone Number: Postcode:

| | Surname | Given Names | Address |
|---|---|---|---|
| Drivers Details: | | | |

Contact Phone Number: Postcode:

Give details of the OTHER vehicle involved in the accident

| Registration Number: | Year | Make (e.g. Holden) | Model (e.g. Commodore) |
|---|---|---|---|
| | | | |

Was their vehicle insured?: Yes ☐ No ☐ If Yes, state Name of Insurance Company:

Was the OTHER vehicle damaged as a result of this accident

Place "X" on diagram to show areas of damage: Front Rear

## WITNESSES

Did any independent person/s witness the accident? Yes ☐ No ☐ If Yes, give details:

| | Surname | Given Names | Address |
|---|---|---|---|
| WITNESS 1: | | | |

Contact Phone Number: Postcode:

| | Surname | Given Names | Address |
|---|---|---|---|
| WITNESS 2: | | | |

Contact Phone Number: Postcode:

# DECLARATION

☐ I wish to report this accident, but do not want to claim against my policy at this time.

☐ I submit this information in support of a formal claim against my policy

The information and answers given in this document are true and correct.
No information likely to affect the acceptance of this claim has been withheld.
I/We understand that this claim may be refused if any information is false, or inaccurate or concealed.

"We the undersigned hereby acknowledge and agree to the information contained herein (including our personal information) being shared with the other members of our JLT Discretionary Trust (Trust) as part of the Trust's Risk Management processes and reporting criteria."

| | ← Please Print Name | | ← Please Print Name |
|---|---|---|---|
| | / / | | / / |
| Signature of Policy Owner (or Company Stamp) | Dated | Signature of Driver | Dated |