

**MSIG**

Mitsui Sumitomo Insurance Company, Limited
 ABN 49 000 525 637
 AFS Licence No.240816

Motor Vehicle Claim (Non Theft)

The issue of this form does not constitute and admission of liability on the part of the insurer.

Policy Number

Claim Number

Please complete all sections. Important: Attach one quotation from repairer.

The Insured										
Full Name (Block Letters)	Surname				Given Name(s)					
Postal Address							State		Postcode	
Are you registered for GST?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What is your ABN?							
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	No <input type="checkbox"/>						Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?			
	No <input type="checkbox"/>						Yes <input type="checkbox"/> – 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 <input type="checkbox"/>						Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?			
	No <input type="checkbox"/>						Yes <input type="checkbox"/> – Specify amount claimed			
Contact Numbers	Business	()				Private	()			
	Facsimile	()				Mobile				

Vehicle Details												
Make of Vehicle					Year	/	/	Registered No.				
Model					Colour			Odometer Reading				
Registered Owner												
Address							State		Postcode			
Do you owe money on your vehicle?										No <input type="checkbox"/>	Yes <input type="checkbox"/>	– Give details
Name of Lender					Account Number							
Address							State		Postcode			

Driver Details												
Full Name (Block Letters)	Surname				Given Name(s)							
Address							State		Postcode			
Contact Numbers	Business	()				Private	()					
	Facsimile	()				Mobile						
Relationship to Insured												
Licence Number					Expiry Date	/	/	Date of Birth	/	/		
How long has the driver been licensed for this type of vehicle?						years						
Did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident?										No <input type="checkbox"/>	Yes <input type="checkbox"/>	– Give details
Did the driver undergo a breath test, breath analysis or blood test?										No <input type="checkbox"/>	Yes <input type="checkbox"/>	– Give details
What was the reading?					(Please attach copy of the certificate.)							

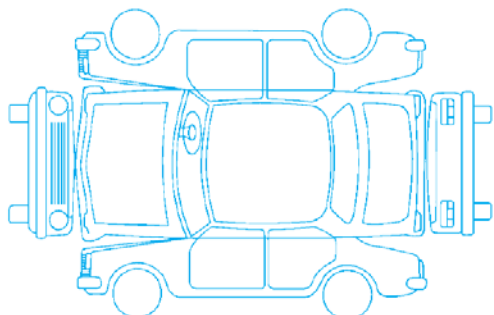
Incident Details

Date	/ /	Day		Time	am/pm
Where did the incident happen?					
Street		Suburb		Nearest Cross Street	
Road surface: Dry <input type="checkbox"/> Wet <input type="checkbox"/> Loose <input type="checkbox"/>					
At the time of the accident the insured vehicle was: Parked <input type="checkbox"/> Stationary <input type="checkbox"/> Moving <input type="checkbox"/> Speed					
Traffic controls: None <input type="checkbox"/> Stop sign <input type="checkbox"/> Traffic Lights <input type="checkbox"/> Roundabout <input type="checkbox"/> Give way sign <input type="checkbox"/> Other <input type="checkbox"/>					
Number of other vehicles involved					
If applicable, what type of goods were being transported at time of loss?					
What happened?					
Who was at fault?	Surname		Given Name(s)		

SKETCH DIAGRAM OF ACCIDENT	
<p>1. Name streets</p> <p>2. Indicate direction of travel</p> <p>3. Your vehicle <input checked="" type="checkbox"/></p> <p>4. Other vehicle <input type="checkbox"/></p>	

Damage to Your Vehicle

Are you claiming for the damage to your vehicle?		No <input type="checkbox"/> Yes <input type="checkbox"/>
Was the vehicle towed?		No <input type="checkbox"/> Yes <input type="checkbox"/> - Give details
Name of tow company		
Where was it towed?	Distance towed	Kms
Where is vehicle now?		

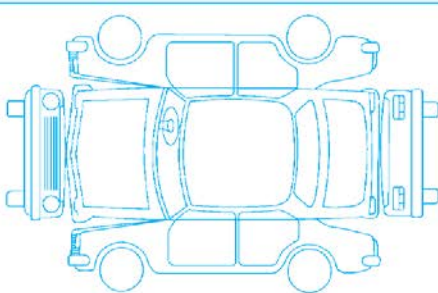
SKETCH DIAGRAM	
<p>Shade in damage to vehicle.</p> <p>Indicate point of impact (X)</p>	

Owner of Other Vehicle

Name	Surname		Given Name(s)		
Address				State	Postcode
Contact Numbers	Business	()	Private	()	
Insurance Co.				Policy No.	

Driver of Other Vehicle				
Name	Surname		Given Name(s)	
Address				State
				Postcode
Contact Numbers	Business	()	Private	()
Date of Birth	/ /	Driver's Licence Number		
Was the owner in the vehicle at the time of the accident?				No <input type="checkbox"/> Yes <input type="checkbox"/>
IF THERE IS MORE THAN 1 OTHER VEHICLE INVOLVED PLEASE ATTACH DETAILS.				

Other Vehicle			
Registration No.	Year of Manufacture	Make of vehicle	
Model		Colour	

Damage to Other Vehicle	
SKETCH DIAGRAM Shade in damage to vehicle. Indicate point of impact (X)	

Other Parties			
Give details of pedestrians, owners of property or owners of animals involved.			
Name	Surname		Given Name(s)
Address			
			Postcode

Police			
Did a Police Officer attend the accident scene, No <input type="checkbox"/> Yes <input type="checkbox"/> or did you report the incident to the police? No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details			
Name			Rank
Station			
Date of report	/ /	(Please attach a copy of the Police Report.)	
Name of person to be charged or cautioned			
Nature of charge or caution			

Witness(es) Details				
Name	Surname		Given Name(s)	
Address				State
				Postcode
Contact Numbers	Business	()	Private	()
Was this witness in the insured vehicle?				No <input type="checkbox"/> Yes <input type="checkbox"/>
Name	Surname		Given Name(s)	
Address				State
				Postcode
Contact Numbers	Business	()	Private	()
Was this witness in the insured vehicle?				No <input type="checkbox"/> Yes <input type="checkbox"/>

Owner(s) and Driver History

In the last 5 years have you as owner or the driver of this vehicle:

1. Had an insurance refused, declined or cancelled by an insurer or any special conditions imposed? Yes No
2. Been convicted or charged with:
 - a) Drug use, driving under the influence, or exceeding Prescribed Concentration of Alcohol? Yes No
 - b) Any driving offences or speeding ? Yes No
 - c) Fraud, arson, theft or any other criminal act? Yes No
3. Had a drivers or motorcycle licence cancelled, suspended or endorsed? Yes No
4. Had a claim or accident? Yes No
5. Had a car stolen or burnt out? (include any not reported or not claimed from an insurer) Yes No
6. Suffered or suffer from impaired eyesight (excluding wearing of glasses), loss of or use of any limb or loss of hearing or from any physical defect or epileptic, diabetic, heart or mental condition? Yes No

If you answered "Yes" to any of the above questions please provide relevant details below

Name of Driver	Date of Incident	Details of each Incident	Your Insurer	Person at Fault
e.g. <i>John Smith</i>	<i>Feb 04</i>	<i>Speeding 80km in 60km zone</i>	<i>-</i>	<i>Self</i>
<i>Bill Jones</i>	<i>Apr 05</i>	<i>Hit third party in the rear</i>	<i>XYZ Co</i>	<i>Bill</i>

If there is insufficient space, please attached a sheet with the relevant information.

Privacy

Mitsui Sumitomo Insurance co. Ltd., includes information about how we manage your personal information in our Product Disclosure Statements. You can obtain a copy of the Mitsui Sumitomo Insurance Privacy Policy from our website www.msi-oceania.com or contact the Privacy Officer on 02 9222 7600 or email msiaus@ms-ins.com.

Declaration and authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/we understand the claim may be refused if information is not true or is withheld.
2. I/we authorise Mitsui Sumitomo Insurance Company Limited to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Signature of insured 1.	<input type="text"/>	Date	<input type="text"/>
Signature of insured 2.	<input type="text"/>	Date	<input type="text"/>

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