MOTOR CLAIM
NOTIFICATION OF ACCIDENT FORM

NAF 05 - 48 e
SICOM General Insurance Ltd
Sir Celicourt Antelme Street, 11302, Port Louis
t: (230) 203 8407 / (230) 203 8400
e: motor.claims@sicom.mu | w: www.sicom.mu

CLAIM No : .....

All questions must be answered fully. This claim form when completed must be returned to SICOM General Insurance Ltd (hereinafter referred to as the Company) without delay. **THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM.**

Insured Details

Surname: ..... First Name: .....

Address: .....

Mob No: ..... Tel No:..... Email: .....

Bank Name: ..... Bank Account No.: .....

Occupation: ..... Employer: .....

Insurance

(a) Policy No: ..... (b) Type of cover: .....

(c) Period: From: _____ / _____ / 20_____ *(dd/mm/yyyy)* To: _____ / _____ / 20_____ *(dd/mm/yyyy)* (d) Excess (Rs): .....

Vehicle

Year of Make	Regd No	H.P or C.C	Year of Purchase	Make	Model	Sum Insured (Rs)

Fitness Expiry : _____ / _____ / 20_____ *(dd/mm/yyyy)* Road Tax Expiry : _____ / _____ / 20_____ *(dd/mm/yyyy)*

Purpose of use

For what purpose was the vehicle being used at time of accident? .....

Was the vehicle in use with the Insured's permission or consent? Yes ☐ No ☐

Driver Details

Surname: ..... First Name.....

NIC No.: ..... Passport No (foreigners): ..... Country: .....

Address: ..... Occupation: .....

Mobile No: ..... *Tel No: Home:* ..... *Office:* .....

Driving Licence No: ..... Date of first issue: _____ / _____ / 20_____ *(dd/mm/yyyy)* Date of expiry: _____ / _____ / 20_____ *(dd/mm/yyyy)*

Category of licence: ..... Endorsed/Suspended: Yes ☐ No ☐

Note: THE DRIVER'S ORIGINAL LICENCE MUST BE SENT TO THE COMPANY FOR INSPECTION.

- Have you been involved in any previous accident? Yes ☐ No ☐
  If yes, give number and details .....
- Have you been prosecuted for any motoring offence? Yes ☐ No ☐
  If yes, give details .....
- Have you ever been refused a motor vehicle insurance or continuance thereof by any insurer? Yes ☐ No ☐
  If yes, give full details .....
- Do you own a motor vehicle? Yes ☐ No ☐
  If yes, give registration no. and insurer .....
- Are you employed by the Insured ? Yes ☐ No ☐
  If yes, in what capacity and for how long? .....

  If no, state relationship to Insured .....

Rough Plan of accident

Please show names and approximate width of roads and indicate tracks of vehicle.

Particulars of accident

Date: _____ / _____ / 20_____ Time: ..... am/pm Place: .....

Road and weather conditions .....

• At what speed were you travelling at time of accident? .....

• Were traffic lights in operation at scene of accident? Yes ☐ No ☐

If yes, were they in your favour? Yes ☐ No ☐

• If the accident happened at night were there any road lights at scene of accident? Yes ☐ No ☐

Full description of accident and events leading up to accident:

.....

.....

.....

.....

Reporting of accident

• Have you reported the accident to the Police Station within one hour? Yes ☐ No ☐

If yes, which Police Station? ..... Date reported: _____ / _____ / 20_____ Time: ____ : _____

If No, reason for not reporting/Late Reporting: .....

• Has any alcohol test been carried out? Yes ☐ No ☐ If Yes, specify result: Positive ☐ Negative ☐

• Do you accept responsibility for the accident? Yes ☐ No ☐ If No, who is responsible: .....

Damage to Insured's vehicle

• Is the vehicle damaged? Yes ☐ No ☐ If yes, extent of damage: .....

.....

• Repairs to be carried out at Garage: ..... Address: .....

NO REPAIRS TO BE CARRIED OUT UNLESS THE COST OF REPAIRS IS APPROVED BY SICOM GENERAL INSURANCE LTD

Particulars of other parties involved in the accident

Insurance Company	Vehicle owner	Make & Model	Reg No	Damages
1.	.....	.....	.....	.....
2.	.....	.....	.....	.....
3.	.....	.....	.....	.....

Injuries

Name and Address of injured	Driver or passenger in own or other vehicle? Relationship to insured or driver	Details of injuries	State Hospital or name and address of Doctor consulted
.....	.....	.....	.....
.....	.....	.....	.....

Customer Declaration

We hereby declare the foregoing particulars to be true and correct and we undertake to render SICOM GENERAL INSURANCE LTD all possible assistance in dealing with this matter. Concealment and Non-Disclosure will render this claim null and void.

The Policyholder understands and agrees that personal data / information shall be exchanged amongst relevant insurers through a common exchange portal for the purpose of claims handling and recovery processes in strict accordance with applicable Data Protection laws and statutory obligations.

Date: _____ / _____ / 20_____ Signature of Driver: .....

Date: _____ / _____ / 20_____ Signature of Insured: .....

Scenario Type

For Office use only

More than two vehicles involved	☐	State owned vehicles involved	☐	Material damage to property	☐
Driver under alcohol or drug influence	☐	Serious casualties involved	☐	Vehicle caught fire	☐
No valid Driving license	☐	No valid insurance vignette	☐	Drivers do not agree	☐
Stolen vehicles	☐	Own damage	☐	Flooding	☐
Others	☐				

Received by : ..... Checked by : .....

Date: _____ / _____ / 20_____ Date: _____ / _____ / 20_____

Remarks :