

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.**

<b>Insured Details</b>	Surname: _____ First Name: _____		
	Address: _____		
	Mob No: _____ Tel No: _____ Email: _____		
	Bank Name: _____ Bank Account No.: _____		
	Occupation: _____ Employer: _____		
<b>Vehicle</b>	Registration No	Policy No	Excess
			Sum Insured (Rs)
	Fitness Expiry : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)		Road Tax Expiry : <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)
<b>Purpose of use</b>	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 <input type="checkbox"/> No <input type="checkbox"/>		
<b>Driver Details</b>	Surname: _____ First Name: _____		
	NIC No.: _____ Passport No (foreigners): _____ Occupation: _____		
	Address: _____		
	Mobile No: _____ Email Address: _____		
	Driving Licence No: _____ Date of first issue: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (dd/mm/yyyy)		
	Category of licence: _____ Endorsed/Suspended: Yes <input type="checkbox"/> No <input type="checkbox"/>		
	<b>Note: THE DRIVER'S ORIGINAL LICENCE MUST BE SENT TO THE COMPANY FOR INSPECTION.</b>		
	• Have you been involved in any previous accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give number and details _____		
	• Have you been prosecuted for any motoring offence? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give details _____		
	• Have you ever been refused a motor vehicle insurance or continuance thereof by any insurer? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give full details _____		
	• Are you employed by the Insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, in what capacity and for how long? _____ If no, state relationship to Insured _____		
<b>Rough Plan of accident</b>	Please show names and approximate width of roads and indicate tracks of vehicle.		
<b>Damage to Insured's vehicle</b>	<b>NO REPAIRS TO BE CARRIED OUT UNLESS THE COST OF REPAIRS IS APPROVED BY SICOM GENERAL INSURANCE LTD</b>		
	• Is the vehicle damaged? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, extent of damage: _____		
	• Repairs to be carried out at Garage: _____ Address: _____		

**Particulars of accident**

Date:         Time:   :    /  Place: \_\_\_\_\_  
am pm

Road and weather conditions \_\_\_\_\_

- At what speed were you travelling at time of accident? \_\_\_\_\_

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:         Time:   :

(dd/mm/yyyy)

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: \_\_\_\_\_

	Insurance Company	Vehicle owner	Registration No	Make & Model
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

Damages to Third Party:

1. \_\_\_\_\_

2. \_\_\_\_\_

	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:         (dd/mm/yyyy) Signature of Driver: \_\_\_\_\_

Date:         (dd/mm/yyyy) Signature of Insured: \_\_\_\_\_

**For Office use only**

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

Received by : _____ Checked by : _____	Provision: _____
Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(dd/mm/yyyy)</small>	Surveyor: _____
Date: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>(dd/mm/yyyy)</small>	Surveyor Code: _____
	Remarks: _____