MOTOR CLAIM
NOTIFICATION OF ACCIDENT FORM

CLAIM No : .....

NAF 05 - 48 c
SICOM General Insurance Ltd
Sir Celicourt Antelme Street, Port Louis
t: (230) 203 8407 / (230) 203 8400 f: (230) 208 9373
e: motor.claims@sicomgin.mu | w: www.sicom.mu

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

Name: ..... Occupation: .....

Address: ..... Employer: .....

Tel No: ..... Email: ..... VAT Reg No: .....

Insurance

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

(c) Excess: ..... (d) Period: .....

Vehicle

Year of Make	Regd No	H.P or C.C	Year of Purchase	Make / Model	Sum Insured

Lien

Has any party a financial interest in the vehicle? Yes ☐ No ☐

If yes, give details .....

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? .....

Driver Details

Name: ..... Date of birth: .....

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

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

Driving Licence No: ..... Date of FIRST issue: ..... Date of expiry: .....

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

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

- Do you have any physical incapacity? Yes ☐ No ☐
  If yes, give details: .....
- 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: ..... 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:

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.....

Witnesses of accident

NAMES AND ADDRESSES OF ALL WITNESSES

PASSENGERS	INDEPENDENT

• Have you reported the accident to the Police Station? Yes ☐ No ☐ Date and time reported: .....

If yes, which Police Station? .....

If No, reason for not reporting: .....

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

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

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 TO THE VEHICLE UNLESS THE ESTIMATE OF COST OF REPAIRS IS APPROVED BY SICOM GENERAL INSURANCE LTD

Particulars of other parties involved in the accident

Name / Insurer	Address	Make & Regd No	Damages
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

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 in every respect and we undertake to render SICOM GENERAL INSURANCE LTD all possible assistance in dealing with this matter. Concealment and Non-Disclosure may render this claim null and void.

The Policyholder understands and agrees that personal data shall be exchanged amongst relevant insurers through a common exchange portal, solely and exclusively for the purpose of claims handling and recovery processes. The Policyholder understands and agrees that the exchange portal's server shall be hosted by the Insurers' Association of Mauritius in strict accordance with applicable Data Protection laws.

Date: ...../...../..... Signature of Driver: .....

Date: ...../...../..... Signature of Insured: .....

For Office use only

Received by :	Checked by :	Remarks :
Date : ...../...../.....	Date : ...../...../.....	