



Motor Vehicle Claim (Non Theft)

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

Policy No.

Claim No.

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?	<input type="text"/>
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	%	<input type="text"/>
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	%	<input type="text"/>
Contact Numbers	Business ()	Private ()	
	Facsimile ()	Mobile	

VEHICLE DETAILS

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

DRIVER DETAILS

Name	Surname	Given Name(s)			
Address	<input type="text"/>			State	Postcode
Contact Numbers	Business ()	Private ()			
	Facsimile ()	Mobile			
Relationship to Insured	<input type="text"/>				
Licence Number	<input type="text"/>	Expiry Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Date of Birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
How long has the driver been licensed for this type of vehicle?		<input type="text"/> 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.
<input type="text"/>					
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? <input type="text"/> (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 Wet Loose

At the time of the accident the insured vehicle was: Parked Stationary Moving Speed

Traffic controls: None Stop sign Traffic Lights Roundabout Give way sign Other

Number of other vehicles involved

If applicable, what type of goods were being transported at time of loss?

What happen?

Who was at fault? Surname Given Name(s)

SKETCH DIAGRAM OF ACCIDENT

1. Name streets
2. Indicate direction of travel
3. Your vehicle
4. Other vehicle

DAMAGE TO YOUR VEHICLE

Are you claiming for the damage to your vehicle? Yes No

Was the vehicle towed? No Yes - Give details.

Name of tow company

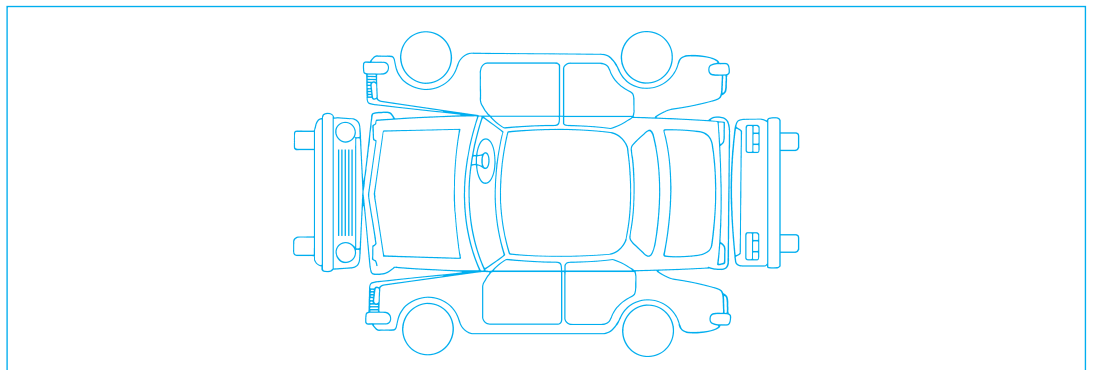
Where was it towed? Distance towed Kms

Where is vehicle now?

SKETCH DIAGRAM

Shade in damage to vehicle.

Indicate point of impact (X)



OWNER OF OTHER VEHICLE

Name	Surname <input type="text"/>	Given Name(s) <input type="text"/>
Address	<input type="text"/>	
	State <input type="text"/>	Postcode <input type="text"/>
Contact Number(s)	Business (<input type="checkbox"/>)	Private (<input type="checkbox"/>)
Insurance Co.	<input type="text"/>	Policy No. <input type="text"/>

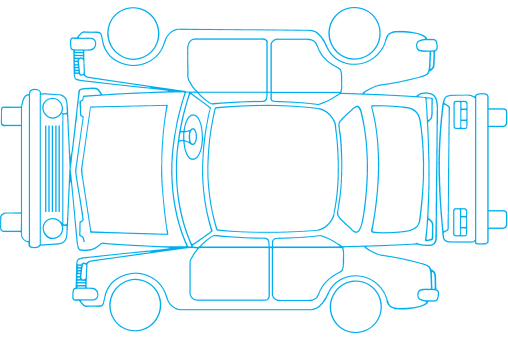
DRIVER OF OTHER VEHICLE

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

OTHER VEHICLE

Registration No.	<input type="text"/>	Year of Manufacture	<input type="text"/>	Make of vehicle	<input type="text"/>
Model	<input type="text"/>			Colour	<input type="text"/>

DAMAGE TO OTHER VEHICLE

SKETCH DIAGRAM Shade in damage to vehicle. Indicate point of impact (X)	
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OTHER PARTIES

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

POLICE

Did police 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	<input type="text"/> / <input type="text"/> / <input type="text"/> (Please attach a copy of the Police Report.)
Name of person to be charged or cautioned	<input type="text"/>
Nature of charge or caution	<input type="text"/>

WITNESS(ES) DETAILS

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

WITNESS(ES) DETAILS (continued)

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

OWNER(S) AND DRIVER HISTORY

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

- Had an insurance refused, declined or cancelled by an insurer or any special conditions imposed? Yes No
- Been convicted or charged with:
 - Drug use, driving under the Influence, or exceeding Prescribed Concentration of Alcohol? Yes No
 - Any driving offences or speeding infringements? Yes No
 - Fraud, arson, theft or any other criminal act? Yes No
- Had a drivers or motorcycle licence cancelled, suspended or endorsed? Yes No
- Had a claim or accident? Yes No
- Had a car stolen or burnt out? Yes No
(include any not reported or not claimed from an insurer)
- 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. John Smith	Feb 94	Speeding 80 km in 60 km zone	-	Self
Bill Jones	Apr 95	Hit third party in the rear	XYZ Co	Bill

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

PRIVACY

The QBE Privacy Promise Brochure explains what sort of personal information we collect and hold about you and what we do with that information. Please contact your Financial Services Provider to obtain a copy of the QBE Privacy Promise Brochure. A copy of the brochure may also be obtained from any QBE Commercial office or from our website at www.qbecommercial.com

DECLARATION AND AUTHORISATION

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

I understand the claim may be refused or reduced if information is withheld.

I authorise that QBE Insurance (Australia) Limited 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 _____ Date / /

Signature of Driver _____ Date / /

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.