

MOTOR VEHICLE CLAIM FORM

Policy Number Claim Number

INSURED DETAILS

Name of Insured:
 Address:
 Contact Details: Ph Work Ph Home
 Mobile Fax
 Email
 Occupation:

VEHICLE DETAILS

Year: Make: Model:
 Type: Registration: Cert Of Fitness Expiry:
 Is the vehicle modified? Yes No (if YES please provide further detail)

 Is the Insured the owner of this vehicle? Yes No (if NO please provide further detail)

DETAILS OF DRIVER / OPERATOR / PERSON IN CHARGE OF VEHICLE

Name:
 Address:
 Contact Details: Ph Home Mobile
 Date Of Birth:
 Occupation: Relationship to Insured:
 Licence Details: Licence Number Number of Years Held:
 Type Full Restricted Learner
 Classes Held 1 2 3 4 5 6
 Endorsements P F V D T R W I
 Was the vehicle being driven with the owner's consent? Yes No (if NO please provide further detail)

 Did the driver consume any liquor and/or drugs within the 12 hours prior to the accident? Yes No
 (if YES please provide further detail)

 Did the Police attend the accident? Yes No (if YES please provide Officers name and Station)

 Was anyone required to undergo a breath or blood alcohol test? Yes No (if YES please provide further detail)

 Has the driver received any traffic offences (other than parking) in the last 5 years? Yes No
 (if YES please provide further detail)

 Has the driver been involved in any motor accidents in the last 5 years? Yes No
 (if YES please provide further detail)

DETAILS OF THE ACCIDENT OR LOSS

What type of claim are you making?

Where did it happen? Street:

Suburb: City:

When did it happen? Date: Day Time am pm

Weather Conditions: Road Conditions:

Were your headlights on and functioning at the time of the accident? Yes No

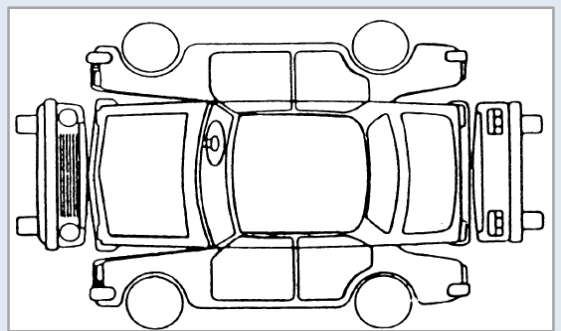
Please provide a description of the accident: *(you may also wish to draw a diagram on the reverse of this page)*

Who do you believe is responsible? Yourself Other (please state)

DETAILS OF DAMAGE TO VEHICLE

Please provide a brief description of the damage that has occurred to the vehicle:

(please also indicate where damage has occurred on the diagram)



Is the vehicle able to be driven safely? Yes No

Where is the vehicle now?

Name Ph Number

Address

If an estimate of repair costs is known, please provide detail \$

DETAILS OF THE OTHER PARTY INVOLVED IN THE ACCIDENT

Name:

Address: Street

Suburb City

Ph Number: Work Home Mobile

Does the other party have insurance? Yes No *(if yes please provide further detail)*

Vehicle Details:

Year Make Model

Type Registration Number

Please provide detail of damage to other vehicle:

DETAILS OF ANY PASSENGERS

| | | | | |
|------------|----------------------------|----------------------|---------------------------|-----------------------------|
| Name: | <input type="text"/> | | | |
| Address: | Street | <input type="text"/> | | |
| | Suburb | <input type="text"/> | City <input type="text"/> | |
| Ph Number: | Work | <input type="text"/> | Home <input type="text"/> | Mobile <input type="text"/> |
| | Name: <input type="text"/> | | | |
| | Address: | Street | <input type="text"/> | |
| Suburb | | <input type="text"/> | City | <input type="text"/> |
| Ph Number: | Work | <input type="text"/> | Home <input type="text"/> | Mobile <input type="text"/> |

DETAILS OF ANY INDEPENDENT WITNESSES

| | | | | |
|------------|----------------------------|----------------------|---------------------------|-----------------------------|
| Name: | <input type="text"/> | | | |
| Address: | Street | <input type="text"/> | | |
| | Suburb | <input type="text"/> | City <input type="text"/> | |
| Ph Number: | Work | <input type="text"/> | Home <input type="text"/> | Mobile <input type="text"/> |
| | Name: <input type="text"/> | | | |
| | Address: | Street | <input type="text"/> | |
| Suburb | | <input type="text"/> | City | <input type="text"/> |
| Ph Number: | Work | <input type="text"/> | Home <input type="text"/> | Mobile <input type="text"/> |

DECLARATION AND PRIVACY ACT

Pursuant to the PRIVACY ACT 1993 the following is brought to your attention

- (a) This claim form collects personal information about you
- (b) The information is collected to evaluate your claim
- (c) The intended recipient of the information is Zurich Auto
- (d) The information is being collected and held by Zurich Auto, P.O. Box 11449, Ellerslie, Auckland
- (e) The collection of this information is required pursuant to the terms of your insurance policy;
- (f) The failure to provide this information may result in you claim being declined;
- (g) You have the rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993

DECLARATION: Note: Failure to provide full and truthful information could result in the claim being declined

I/We declare that the information given in this form is correct.

I/We agree that, should there be any dispute over any payment of this claim, Zurich Auto shall be entitled to submit the dispute to arbitration.

I/We authorise and request the New Zealand Police to release to Zurich Auto copies of any documents held by the New Zealand Police relating to the incident giving rise to this claim. If necessary, authority should be treated as a formal request pursuant to the Official Information Act, 1982.

I/We authorise the disclosure of personal information held by any other party regarding this claim.

I/We agree to Zurich Auto releasing to other parties personal information regarding this claim.

I/We authorise the insurer or its authorised agent to give or obtain from the other insurers or other parties any information relating to any insurance held or claim made.

I/We authorise you to place details of this claim on the database of ICR Ltd, PO Box 474, Wellington, where it will be retained and be available to other insurance companies to inspect.

I/We solemnly declare that the information given & contained in this document is true & correct by virtue of the Oaths & Declarations Act, 1957. I/We acknowledge that if any information given is incorrect or has been concealed it may result in the claim being declined.

Please complete: I HAVE READ THE ABOVE AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE ANSWERS PROVIDED IN THIS FORM ARE TRUTHFUL.

Name of person who completed this form

LIVE DOCUMENT INSTRUCTIONS AND HELP

When viewing this document on a PC using Adobe Reader you are able to complete the questions on screen. If you are not clear on what a question is asking simply move your mouse over the relating answer box and a 'pop up' hint will appear to assist you further. At the beginning of the form you will find a RESET button which will clear all of the answer boxes back to their original or default status (allowing you to easily re-use the form or start afresh) Once you have complete all the relevant questions you have the option of:

- a) Printing the form off and posting to us;
- b) Faxing the form to us on 09 583 0700;
- c) Emailing us the data simply by clicking on the 'EMAIL CLAIM' button.