MOTOR ACCIDENT CLAIM FORM

Please print in block letters using black or blue ink.

Old Mutual Short-Term Insurance Company (Namibia) Limited
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AGENT/BROKER

Policy no.

Claim no.

DETAILS OF INSURED

Name

Surname

Identity no.

VAT registration no.

Business or occupation

Physical address

Telephone numbers Day

DETAILS OF VEHICLE

Make

Model and year

Tare

Gross vehicle mass

Kilometers completed

Registration number

Value N$

Date of purchase D D M M Y Y Y Y

If vehicle subject to hire purchase, credit or leasing agreement, state name and address of finance company.

Name of company

Address

In whose name is the vehicle registered?

DETAILS OF DAMAGE TO VEHICLE

Damage to own vehicle

Repairer's name

Repairer's address

Repairer's telephone number

Where can your damaged vehicle be inspected?

DETAILS OF DRIVER

Full names

Surname

Identity no. Occupation

Address

Driving licence Number Date D D M M Y Y Y Y

Place Full/Learner

State fully the purposes for which the veicle was being used.

Was he/she driving with your permission? YES NO

Was he/she employed by you? YES NO

Is he/she the owner of another vehicle? YES NO

If "YES", please provide name of insurer and policy number.

Name of insurer

Policy number

Details of any convictions for motoring offences.

Has the licence ever been endorsed? YES NO

Does he/she have an disabilities? YES NO

Details of previous accidents.

DETAILS OF INJURED PERSONS IN OWN VEHICLE

Name

Address

Injury

Name

Address

Injury

Name

Address

Injury

For what purpose were they carried?

Were they employees? YES NO

DETAILS OF INJURED PERSONS IN OTHER VEHICLES

Registration number | Make

Name of owner

Address of owner

Name of driver

Address of driver

Details of damage

Contact details: Home | Work

Cellphone number

Insurance details: Company name

Policy number | Claim number

Details of damage

Property other than vehicles

Name of owner

Address of owner

Details of damage

Personal injuries (other than in insured's vehicle)

Name of injured

Relationship to accident e.g. driver, passenger etc. | Name of hospital, if applicable

Address

Telephone number

Name of injured

Relationship to accident e.g. driver, passenger etc. | Name of hospital, if applicable

Address

Telephone number

Date of accident D D M M Y Y Y Y | Time of accident | Place where accident occurred

Speed: Before accident kph | At impact kph

Weather condition | Visibility

Condition of road surface | Width of road metres

Which vehicle lights were on? | Street lighting

Name of police/traffic officer who recorded the details of the accident

Name of Police station | Police reference no.

Description of accident

Sketch of accident (if necessary use)

Please show clearly the point of impact and indicate the direction of travel by arrows. Give details of any road safety signs or warning signs in vicinity of scene of accident.

I have inspected the driver's licence and it is free of endorsements/endorsed as shown. Please attach copies of driver's licence and page 1 of driver's identity document.

Insured's signature

Capacity

Date D D M M Y Y Y Y

DECLARATION

We hereby declare the following particulars to be true in every respect.

Signature of driver

Insured's signature

Capacity

Date D D M M Y Y Y Y

NOTE
It is important that you notify the insurers immediately as soon as you become aware of any impending prosecution, inquest or demand.
Any personal injuries noted overleaf must be reported separately to the multilateral motor vehicle accidents fund without delay.