Motor Vehicle Claim Form

GSI Insurance Partners

N.B. This form must be completed by the driver.
Please answer all questions. If not applicable, please write N/A.

Pursuant to the Privacy Act 2020 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: The insurer named below (hereinafter called "the Company") and is being held by them at their Head Office
(d) The collection of this information is required pursuant to the terms of your insurance policy;
(e) The failure to provide this information may result in your claim being declined;
(f) You have rights of access to, and correction of, this information subject to the provisions of the Privacy Act 2020
(g) We collect, use, disclose and hold your personal information in accordance with the Privacy Act 2020 and our Privacy Statement is available at **www.gsi.nz** or by requesting a copy at any time.

INSURANCE COY: _____ **POLICY NO:** _____

A. Policy Holder

Full Name of insured or Name of Company: _____

Postal Address: _____

Telephone (Day): _____ Telephone (Night): _____

Email Address: _____

Name of any other party with financial interest in the vehicle: _____

Is there any other insurance on the vehicle or accessories? Yes ☐ No ☐

B. Insured Vehicle

Make: _____ Model: _____ Type: (e.g. Van, Car, Arctic, Flat-Top etc.) _____

Year: _____ REGO NO: _____ Has the vehicle been modified in any way: _____

Is the vehicle a used import? Yes ☐ No ☐ Does the vehicle have a current Certificate of Fitness? Yes ☐ No ☐

C. Person Driving or in charge of the Insured Vehicle (TO BE COMPLETED, EVEN IF PARKED)

Full Name: Mr / Mrs / Miss / Ms: _____ Date of Birth: _____

Postal Address: _____

Telephone (Home): _____ Telephone (Business): _____

Occupation: _____ Relationship to Policy Holder: _____

Drivers Licence No: _____ Type: _____ Year Held: _____ Date & Country of Issue: _____

Licence Classes (Please List): _____ Version No: _____ Licence Special Conditions (Please List): _____

Please Complete

1. Was the Vehicle being driven with the owner's consent? Yes ☐ No ☐
   If NO, please provide detail: _____
2. Is he/she the main driver of the Insured vehicle? Yes ☐ No ☐ _____
3. If not the Policyholder do you own a vehicle? (Name of Insurance Co) Yes ☐ No ☐
   If YES, please provide detail: _____
4. Did driver consume liquor and/or drugs (include medication) within 24 hours prior to the accident? Yes ☐ No ☐ _____
5. Did the Police attend? Yes ☐ No ☐
   If YES, what is the Police file number? _____
6. Have the police laid or mentioned laying charges against the driver of your vehicle? Yes ☐ No ☐
   If YES, do you know what the charges are likely to be? _____
7. Was a breathalyzer, or blood test, or any other such test done? Yes ☐ No ☐ _____
8. During the past 5 years, have you:
   (i) Been convicted of any offence other than parking (type and penalty) Yes ☐ No ☐ _____
   (ii) Had any other accident, loss of claim in connection with any motor vehicle (brief details of year/cost/insurance coy) Yes ☐ No ☐ _____

D. Details of Other Persons

Passengers of Your Vehicle:

Name: _____ Address & Phone: _____

Name: _____ Address & Phone: _____

Independent Witnesses:

Name: _____ Address & Phone: _____

Name: _____ Address & Phone: _____

Driver/Owner of Other Vehicle or Property:

Name: _____ Address & Phone: _____

Insurance Co: _____ Details of Vehicle & Property: _____

Registration Number: _____

E. Details of Loss or Accident (Please continue on seperate sheet if necessary):

Date: _____ Time: _____ AM ☐ PM ☐

Location (e.g. Street): _____ Suburb/Town: _____

Weather: Rain ☐ Fog ☐ Overcast ☐ Bright Sun ☐ Clear Sky ☐ Speed Limit was in force: 50Km/Hr ☐ 100Km/Hr ☐ Other ☐

Road: Wet ☐ Dry ☐ Metal ☐ Sealed ☐

Your speed prior to braking: _____ At Impact: _____ Reason for journey: _____

Describe in detail how the accident occurred: _____

What, in your opinion, caused the accident? _____

Was anyone hurt in the accident? Yes ☐ No ☐ If 'Yes', can you please extent advise who, their relationship to the driver & known of the injuries

F. Sketch Plan of Accident (Please continue on a separate sheet, if necessary)

Indicate: Street Names , direction of vehicles.

Your Vehicle →

Other Vehicle ⋯→

F. Damage to Insured Vehicle (NB: DO NOT proceed with repairs without the Company's Authority):

Describe damage: _____

Repairer: _____ Telephone: _____ Estimate: _____

If not at above, Date of Repair: _____ OR Where vehicle can be inspected: _____

DECLARATION:

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

1) I/We agree to The Company disclosing my/our personal information regarding this claim to:
(a) Other parties including other members of the Insurance Industry and the data base of the Insurance Claims Register (ICR Ltd)
P.O. Box 474, Wellington, where it will be retained and made available to other insurance companies to inspect.
(b) Parties who have a financial interest in the subject matter of the policy and parties repairing or replacing the subject matter of the claim.
(c) I/We understand that I am/We are entitled to have certain rights of access to and correction of the personal information held by The Company and ICR Ltd.

2) I/We agree to The Company obtaining personal information about me/us that is, in The Company's view, relevant to this claim:
(a) From any other party including other members of the Insurance Industry and from Insurance Claims Register Ltd (ICR Ltd) Which holds details of claims made by me/us under policies with other insurers.
All the information and answers (whether written or oral) given to The Company in connection with this claim are correct and that no information relevant to the claim has been omitted. I/We authorize The Company to act on my/our behalf.

Policy Holders Signature: _____ Date: _____

Drivers Signature: _____ Date: _____

IBANZ INSURANCE BROKERS ASSOCIATION OF NEW ZEALAND INC