



# COMMERCIAL MOTOR VEHICLE CLAIM FORM

**TRUCKSURE PTY LTD**  
A.B.N 78 078 661 220 AFSL: 238151

Please complete all sections of the Claim Form clearly and forward to Trucksure Pty Ltd.  
No repairs or alterations to the damaged vehicle should be made until approved by Trucksure Pty Ltd  
Please note that the information on this form should not be construed as an admission of liability and is done so without prejudice. **Please complete sections 1-12**

## 1. INSURED

Name of the Insured	ABN
Trading Name	
Postal Address	
Phone Number. Private	Business
Policy Number	Occupation
Broker Name	

## 2. OTHER INTERESTED PARTIES

Does any other party have any financial interest in the vehicle or trailer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of the Interested Party	
Address	Postcode
Type of Interest	HP <input type="checkbox"/> Lease <input type="checkbox"/> P/Loan <input type="checkbox"/> Mortgage <input type="checkbox"/> Other <input type="checkbox"/>

## 3. YOUR VEHICLE(S)

Make & Model			
Body Type	Transmission	Reg. No.	
Carrying Capacity	Engine No.		
Tachograph fitted	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cruise Control fitted	Yes <input type="checkbox"/> No <input type="checkbox"/>
Speed limiter fitted	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "YES", what is the maximum speed?	km/hr
Make & Model Trailer(s)			
Reg. No.	owned/un-owned		
Has the vehicle or trailer been modified or converted from the manufacturer's specification or fitted with accessories other than those supplied at the maker's options? Yes <input type="checkbox"/> No <input type="checkbox"/>			
"YES", describe modifications			



Details of LAST employer?
Type of Driving Experience with Employer listed above?
Type of Licence held with this employer listed above?
If Employee driving, was he/she acting within the scope of his/her employment? Yes <input type="checkbox"/> No <input type="checkbox"/>
Give particulars of all previous motor vehicle accidents in which you were involved

Have You:	(a) had a policy of Insurance cancelled or declined, or increased excess imposed, or endorsed with special conditions imposed? Yes <input type="checkbox"/> No <input type="checkbox"/>
	(b) had a driver's licence suspended or cancelled? Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) been issued with any traffic infringement notices or been convicted of any traffic offences? Yes <input type="checkbox"/> No <input type="checkbox"/>
	(d) did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If "YES" to any of the above, state particulars

**7. ACCIDENT**

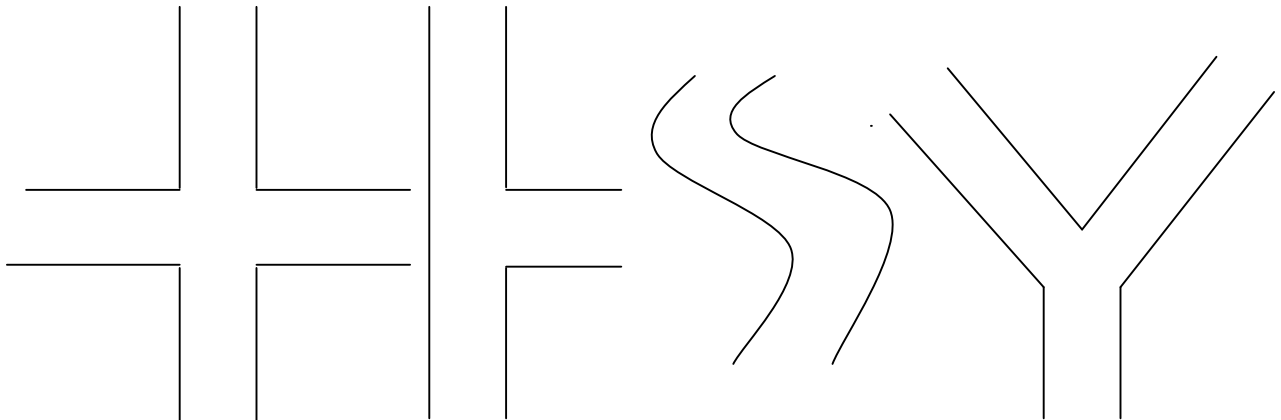
<b>Date of accident/theft</b>	<b>Time</b>	<b>am/pm</b>
Place where accident/theft occurred	Street/Road/Hwy	
Suburb or Town	Postcode	
Estimated speed of motor vehicle at time of accident	kph	20 m from accident kph
How many vehicles were involved?		
How did the incident happen? Please describe in detail the circumstances leading up to the accident and the accident as seen by the driver. Please attach a separate piece of paper if the space below is insufficient. Do not hide any facts that may not be in your favour. <i>Please print/write clearly</i>		

On what side of the road was your vehicle being driven at time of accident?	
Road type	Single / Dual / Multi Lane
What was the condition of the road wet / dry / rough, if other please describe	
If the accident occurred after dusk,	(a) were lamps alight on your vehicle Yes <input type="checkbox"/> No <input type="checkbox"/>
	(b) were lamps alight on other vehicle Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c) was road well lit Yes <input type="checkbox"/> No <input type="checkbox"/>
Was a trailer attached to your vehicle at time of accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you of the opinion the accident was caused or contributed to by the fault or negligence of any person other than your driver? Yes <input type="checkbox"/> No <input type="checkbox"/> Please state your reason for thinking so	
Please give details of conversation between your driver and the driver of the other vehicle immediately after the accident	

**8. SKETCH PLAN OF ACCIDENT**

Please complete below the plan design applicable to the accident. If necessary, alter the design to suit the particular scene. Indicate centre of roadway, direction and location of vehicles, and location and nature of traffic control signs. Please mark using the following symbols:

Your Vehicle **I** Other party's vehicle **O** Point of impact with **X** Direction of each vehicle ← →



Indicate north with an arrow

### 9. DETAILS OF OTHER VEHICLES INVOLVED IN ACCIDENT

Owner's Name	
Address	
Driver's Name	
Address	
Phone No.	Licence No.
Name of other party's Insurer	Policy No.
Registration No.	Type (i.e. taxi/truck or private car)
Make of Vehicle	Colour
Number of persons in vehicle and their names	
Nature of damage to other party's vehicle or property	
Estimate \$	
Have you received any letters or notifications from the other party above? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If so, for what amount? \$	Please attach all correspondence received

### 10. OTHER VEHICLE NO 2

Owner's Name	
Address	
Driver's Name	
Address	
Phone No.	Licence No.
Name of other party's Insurer	Policy No.
Registration No.	Type (i.e. taxi/truck or private car)
Make of vehicle	Colour
Number of persons in vehicle and their names	
Nature of damage to other party's vehicle or property	
Estimate \$	
Have you received any letters or notifications from the other party above? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If so, for what amount? \$	Please attach all correspondence received

## 11. WITNESSES

Name
Address
Phone No.

## 12. POLICE

Did a Police Officer attend the accident scene?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did a Police Officer take particulars?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name the Police Officer	To which station is he/she attached?
Police Event / File number	
Is Police action pending against either party?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, against whom, and what is the charge?	
To which station is he/she attached?	
Was a breathalyser or blood test administered (or refused)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, what was the reading (amount)?	If refused, why?

**Please supply a copy of your Log Book for the last 72 Hours and a copy of your Drivers Licence.**

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### **DECLARATION**

I / We declare that to the best of my / our knowledge and belief the information in this form is true and correct and I / We have not withheld any relevant information.

I / We consent to Trucksure Pty Ltd using my personal information I / We have provided on this form for the purpose of processing my claim. I / We understand that if I / We choose not to provide the required details, this is my choice; however, Trucksure Pty Ltd may not be able to process my claim.

Driver's Signature \_\_\_\_\_ Date \_\_\_\_\_

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_