

PREMIER INSURANCE LIMITED

5th Floor, State Life Building No. 2A, Wallace Road, P.O. Box No. 4140, Karachi-74000, Pakistan.
Phone: (92-21) 3241 6331-4 Fax: (92-21) 3241 6572 Email: info@pil.com.pk Web: www.pil.com.pk

MOTOR VEHICLE ACCIDENT REPORT FORM

THIS FORM SHOULD BE RETURNED DULY FILLED TO THE COMPANY
IMMEDIATELY AFTER AN ACCIDENT

This Form is issued without Prejudice to any of the Stipulations or Conditions of the Company's Policy, and is not to be taken as an admission of liability on the part of the Company.

POLICY No.	LOSS No.
INSURED	Name _____
	Private Address _____ Tel. No. _____
	Business Address _____ Tel. No. _____
PARTICULARS OF INSURED VEHICLE	Make _____ HP / C.C. _____ Year of Make _____
	Type of Body _____ Regn. No. _____ Colour _____
	Chassis No. _____ Engine No. _____
	For what purpose was the vehicle being used at time of Accident ? _____
	How many Passengers were being conveyed? _____
	Was a trailer attached ? _____
	If goods were carried, state nature and weight _____
PARTICULARS OF PERSON DRIVING	Name _____ Age _____
	Address _____
	Licence No. _____ Date of issue _____
	Valid upto _____
	Is he your permanent Paid Driver _____ How long has he been in your employment? _____
PARTICULARS OF ACCIDENT	Date and time of Accident _____
	Date when reported to us _____
	Where did the Accident Occur ? _____
	Was your Vehicle on its correct side ? _____
	If your Vehicle was not on correct side, state its exact position _____
	At what speed was your Motor Vehicle traveling immediately prior to the Accident ? _____
	Please explain exactly how Accident happened _____
Do you consider the person driving your Vehicle to be at fault? _____	

Has the accident being reported to the Police? If so, give name and address of Police Station and state what action, if any, has been or is being taken _____

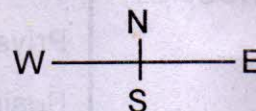
Names and addresses of all witnesses to the accident other than the occupants of your own Vehicle _____

If witnesses' names not taken, give reason _____

Was the driver or any other occupant of your Vehicle injured? Give particulars _____

P L A N

Please make a rough sketch of the road in the space below illustrating the position of Vehicles and persons involved at the time of accident. An arrow should indicate the direction in which they were moving.



DAMAGE TO INSURED VEHICLE

What damage was caused to the insured Vehicle _____

Repairer's name, address and telephone No. _____

Is the Vehicle at the repairer's premises? _____

If not where is it and when will it be taken there? _____

(In all cases where your vehicle is damaged and you are entitled to claim under the policy, please send at once to the Company an estimate for repairs).

THIRD PARTY CLAIM

If any damage/injury was caused by your car to any other car, person or property, please answer the following questions fully:

Name and address _____

Full details of personal injuries or damage to property _____

If any injured person removed to hospital or medically attended, give name and address of the Hospital or Doctor _____

Has notice of any claim been given to you? _____

IMPORTANT Admit no liability in any circumstances but despatch to the Company forthwith and unanswered any written communication which may have been received.

I/We hereby declare the foregoing particulars to be true in every respect

ACCIDENT DEPARTMENT

Claim No. _____

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SATISFACTION NOTE

This is to certify that the repairs authorized to my / our vehicle No. _____ have been carried out to my / our satisfaction and the repairer's account, therefore, may be settled.

NOTE: Settlement of repairers bill is subject to submission of copy of Registration book, valid driving license, filled and signed Claim Form. Workshop to ensure this prior to repairs.

Insured's Signature _____

Dated _____

Address _____
