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 _____

PLAN

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.

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W — E
S

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 desptach 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

Date _____ Insured's Signature _____

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_____

_____