



Better. Simple. Life.

## MOTOR ACCIDENT CLAIM FORM

### IMPORTANT NOTICE

1. No Liability is admitted by Issue of this form \_\_\_\_\_ Insurers Claim No: \_\_\_\_\_
2. Neither owner nor driver may admit fault or Liability Broker Ref. No. \_\_\_\_\_ for this Accident.
3. Do not answer communications about this Accident. Direct these to the Insurance Company for Action
4. Please let us have an estimate of repair cost
5. Repairs must not be authorized without prior authority of the Insurance Company
6. All questions on this form must be answered

*REMEMBER: Incomplete answers will lead to delayed processing of your claim.*

### Insured's Details

Insured \_\_\_\_\_ Policy Number \_\_\_\_\_

Date of payment of last premium \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Email \_\_\_\_\_ Fax \_\_\_\_\_

Business or Occupation \_\_\_\_\_

V.A.T. registration No. \_\_\_\_\_

### POLICY

Number \_\_\_\_\_

Period of Insurance; From: \_\_\_\_\_ To: \_\_\_\_\_

Type of cover \_\_\_\_\_ Comprehensive  TPF&T  TPO

Name of hire purchase or finance company (if any) \_\_\_\_\_

### VEHICLE

Make & Model \_\_\_\_\_ Year of manufacture \_\_\_\_\_

Reg.No. of vehicle \_\_\_\_\_ Carrying capacity \_\_\_\_\_

Reg. No. of trailer \_\_\_\_\_ Capacity \_\_\_\_\_

Name and Address of Owner \_\_\_\_\_

### USE

State the EXACT PURPOSE for which the vehicle was being used at the time of the accident

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## COMMERCIAL VEHICLES

Description of goods being carried \_\_\_\_\_

Name of owner of goods \_\_\_\_\_

Was a trailer attached? \_\_\_\_\_

Weight of load on

(a) Vehicle \_\_\_\_\_ (b) Trailer(s) \_\_\_\_\_

## DRIVERS' DETAILS (even if the insured)

Name \_\_\_\_\_

Occupation \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ Tel No. \_\_\_\_\_

Is he/she employed by you? Yes  No

How long has he/she been in your service? \_\_\_\_\_

Was he/she driving with your permission? Yes  No

How long has he/she been driving motor vehicles? \_\_\_\_\_

Was he/she in any way to blame for the accident? Yes  No

Did he/she admit liability? Yes  No

Has he/she had any previous accidents? Yes  No

If so, how many, an approximate date? \_\_\_\_\_

Has he any conviction for any offence in connection with any motor vehicle or any charges pending?

Yes  No

If so, give details including dates \_\_\_\_\_

Does he/she hold a full or provisional licence to drive this vehicle? Full  Provisional

If full, state date when driving test first passed \_\_\_\_\_

Number \_\_\_\_\_

Does he/she own a Motor Vehicle? Yes  No

If so, give name and address of Insurer \_\_\_\_\_

Driver's Policy No. \_\_\_\_\_

## ACCIDENT

Date \_\_\_\_\_ Time \_\_\_\_\_ a.m./p.m.

Place \_\_\_\_\_

Type of Road surface \_\_\_\_\_

Visibility \_\_\_\_\_ Wet or Dry? \_\_\_\_\_

What lights were showing on your vehicle? \_\_\_\_\_

What warning did your driver give? \_\_\_\_\_

Estimated speed before accident \_\_\_\_\_

Weather condition \_\_\_\_\_

Did Police take particulars? \_\_\_\_\_

If so, give Constable's number and station \_\_\_\_\_

To which Police Station was the accident reported? \_\_\_\_\_

Attach copy Notice of Intended prosecution If any. \_\_\_\_\_

## PLAN OF ACCIDENT

Draw sketch stating approximate measurements showing position of vehicles and persons concerned and the direction in which they were travelling. Also show type and position of traffic signs, skid marks, pedestrian crossings and any other relevant information.

## STATEMENT BY DRIVER

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Signature of Driver \_\_\_\_\_

## STATEMENT BY OWNER OR INSURED

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## DAMAGE TO INSURED VEHICLE

State briefly apparent damage \_\_\_\_\_

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(IN ALL CASES WHERE YOUR VEHICLE IS DAMAGED AND YOU ARE ENTITLED TO CLAIM UNDER YOUR POLICY, PLEASE SEND AT ONCE TO THE COMPANY AN ESTIMATE FOR REPAIRS).

Repairers name and address \_\_\_\_\_

Tel No. \_\_\_\_\_

Is the vehicle still in use? Yes  No

When and where can it be inspected? \_\_\_\_\_

## OTHER VEHICLES INVOLVED

Name and address of owner	Reg. No.	Name of Insurer

## DAMAGED PROPERTY

Name and address of owner	Property damaged

## PERSONS INJURED

Name and address	Relationship to the insured	If driver or passenger, Reg. No. of vehicle	Apparent injuries

## INDEPENDENT WITNESSES

Name \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_

## PASSENGERS IN YOUR VEHICLE

Name \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Declaration

I/We declare that the foregoing answers are true and complete to the best of my/our knowledge

Signature \_\_\_\_\_ Name \_\_\_\_\_

Title \_\_\_\_\_ Date \_\_\_\_\_

We would also like to have your bank details in the format below to facilitate bank transfer payment upon approval of your claim

Bank name: \_\_\_\_\_

Account name: \_\_\_\_\_

Account no.: \_\_\_\_\_

Branch: \_\_\_\_\_

Bank Swift Code: \_\_\_\_\_

Bank Sort Code: \_\_\_\_\_

### UAP Insurance Company Limited

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