

6c Half Way Tree Road, Kingston 5, Jamaica W.I.
 keyins@cwjamaica.com, www.keyinsurancejamaica.com

CLAIM NUMBER _____

PARTICULARS OF INSURED

Date: _____

Name:		Alias:	
Home Address:			
Occupation:		Nationality:	
Employer Name:			
Employer Address:			
Home Phone:	Bus. Phone:	Cell Phone:	
E-mail Address:			
Is there any other policy in force covering this vehicle?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, give details below:	
Were you in the vehicle when the accident took place?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

PARTICULARS OF INSURANCE

Policy Number:		Renewal Date:		Type of Cover:	
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PARTICULARS OF VEHICLE

License Number:		Make/Model:		Year of Make:		Colour:	
Condition of tyres:		Was there any un-repaired damage prior to the accident?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
If yes, give details:							
Name and Address of any Bank or Company financially interested in the vehicle:							
Type of Road Licence:							

PARTICULARS OF USE

State fully the purpose for which the vehicle was being used at the time of the accident:			
Were goods being carried?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, state the nature:	and weight (lb):
How many persons were being conveyed in the vehicle?		Were they charged a fee to be conveyed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Was the vehicle driven by a person other than the insured?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, by whose authority?	
What is the relationship between Driver and Insured?			

PARTICULARS OF DAMAGE TO OWN VEHICLE

Was the vehicle damaged?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, please state the following:
a) Nature of damage:		
b) Approximate cost of repairs: J\$		c) Current location of vehicle:
d) Name and address of repairers:		

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

PARTICULARS OF PERSON DRIVING

Driver's Name:		Alias:	
Driver's Address:			
Occupation:		Date of Birth:	
Home Phone:	Cell Phone:	Bus. Phone:	
Driver's License #:	Date Issued:	At what Tax Office:	
Type of License:	Classes of vehicles specified in license:		
Has it been endorsed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please give particulars:	

PARTICULARS OF PERSON DRIVING (con't.)

Is he/she employed by you to drive?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If so, how much is he/she paid? J\$	<input type="checkbox"/> week <input type="checkbox"/> month
Has he/she been involved in an accident in the past three (3) years?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes , give details below of each accident. Please use separate sheet if more room is required.	

Does he/she own a vehicle?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, where is it insured?
What is the type of cover?	Has he/she ever been refused Insurance or the continuance thereof? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Has he/she any conviction for any offence in connection with any motor vehicle?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes , give details below. Please use separate sheet if more room is required.

If the person is a learner, please answer the following questions:

a) Name of passenger seated beside him/her in the front seat?			
d) Does that passenger have a valid driver's license?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, please state particulars below: -	
Driver's License #:	Date Issued:	At what Tax Office:	
Type of License:	Classes of vehicles specified in license:		
Has it been endorsed?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, state particulars:	
c) State name(s) & address(es) of any other person seated in the vehicle:			

PARTICULARS OF ACCIDENT

Date of Accident:	Approximate time of accident:	<input type="checkbox"/> am <input type="checkbox"/> pm	Your approximate speed at time of accident (km):
Location of Accident:			
What lamps were lit on your vehicle?	<input type="checkbox"/> Head lights	<input type="checkbox"/> Park lights	<input type="checkbox"/> Indicator light(s)
	<input type="checkbox"/> Hazard lights	Was the accident reported to the Police? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did a Police Officer attend the scene of the accident?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Name of Investigating Officer:	
Badge Number:	Contact Number(s):		
Name & Address of Police Station:			
Were you warned for prosecution?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Was the other Driver warned for prosecution:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Was the pavement wet?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Was horn sounded?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Were you wearing your seat belt?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you offered the Third Party any compensation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
		If yes, how much?	

PARTICULARS OF PASSENGERS IN INSURED'S VEHICLE

1. Name:		Alias:	
Address:			
Occupation:		Relationship to insured/driver:	
Hospital attended:		Was passenger wearing seat belt:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nature of injuries, if any:			
2. Name:		Alias:	
Address:			
Occupation:		Relationship to insured/driver:	
Hospital attended:		Was passenger wearing seat belt:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nature of injuries, if any:			

3. Name:		Alias:	
Address:			
Occupation:		Relationship to insured/driver:	
Hospital attended:		Was passenger wearing seat belt:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nature of injuries, if any:			

PARTICULARS OF THIRD PARTIES

1. a) Owner's Name:			
b) Owner's Address:			
c) Driver's Name:			
d) Driver's Address:			
e) Registration no.		f) Type of vehicle:	
g) Insurance Company:			
h) Nature of damage:		e) Cost of repairs: J\$	

2. a) Owner's Name:			
b) Owner's Address:			
c) Driver's Name:			
d) Driver's Address:			
e) Registration no.		f) Type of vehicle:	
g) Insurance Company:			
h) Nature of damage:		e) Cost of repairs: J\$	

3. a) Owner's Name:			
b) Owner's Address:			
c) Driver's Name:			
d) Driver's Address:			
e) Registration no.		f) Type of vehicle:	
g) Insurance Company:			
h) Nature of damage:		e) Cost of repairs: J\$	

Was any pedestrian or cyclist injured?		<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, complete below:	
Name:		Occupation:		
Address:		Damage to cycle:		
Nature of injury (if any):		Hospital attended:		

How many passengers were in the Third Party's vehicle?		How many of the passengers were injured (if any)?	
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State the injured passengers names, addresses, and nature of injuries below:

1.	Name:	Phone #:	
	Address:		
	Occupation:	Nature of injury:	

2.	Name:	Phone #:	
	Address:		
	Occupation:	Nature of injury:	

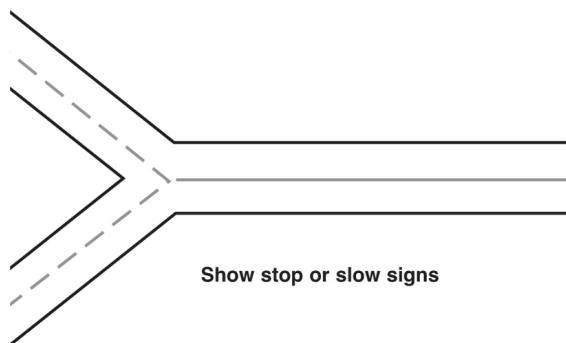
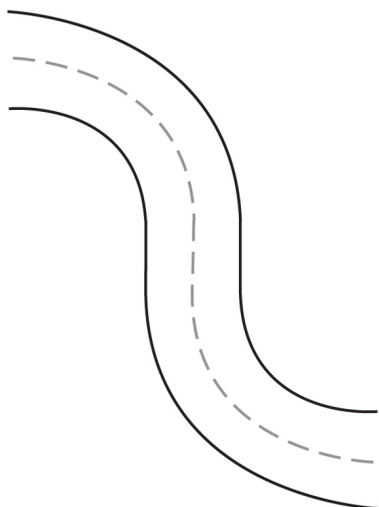
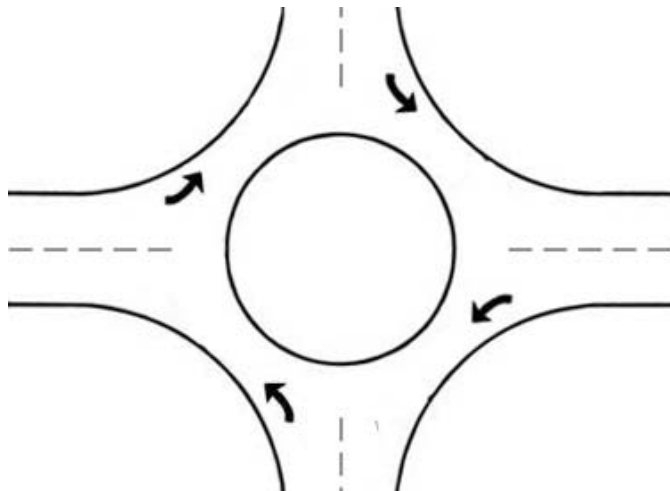
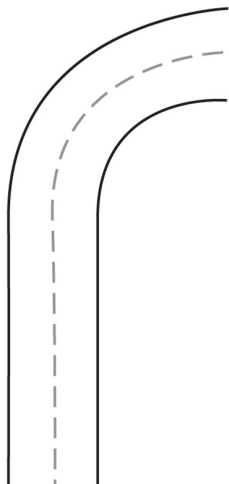
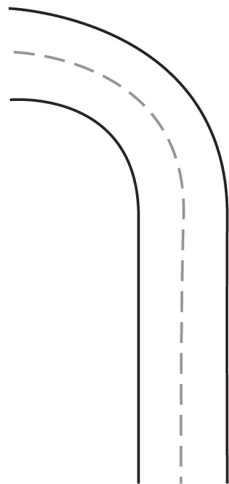
3.	Name:	Phone #:	
	Address:		
	Occupation:	Nature of injury:	

4.	Name:	Phone #:	
	Address:		
	Occupation:	Nature of injury:	

SKETCH AND MEASUREMENTS

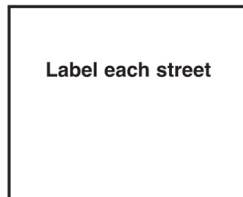
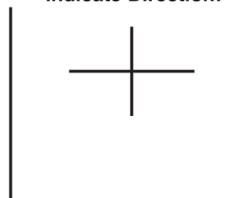
Please state measurements in feet. Show approximate width of road.

1 chain = 66 yards or 198 feet.



Show stop or slow signs

Indicate Direction:



Label each street

