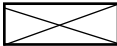
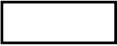


The issue of this form does not constitute an admission of liability on the part of the insurer.

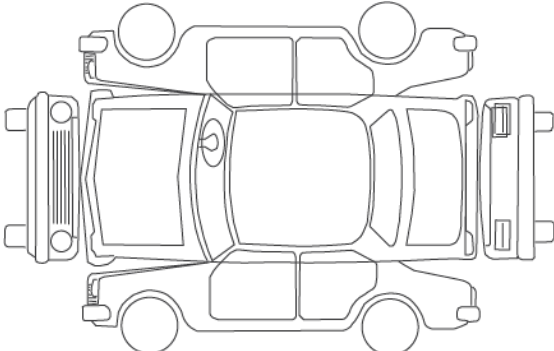
Please complete all sections. **IMPORTANT** Attach one quotation from repairer.

Policy Number		Claim Number	
THE INSURED			
Business Name			
Address			
Suburb		State	Postcode
Are you registered for GST?	<input type="checkbox"/> Yes <input type="checkbox"/> No	ABN	
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the policy?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will you be claiming an amount less than 100%?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount claimed	%
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, will you be claiming an amount less than 100%?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount claimed	%
Business phone	Private phone	Mobile phone	
VEHICLE DETAILS			
Year	Make	Model	
Rego	Colour	Odometer	
Registered Owner			
Address			
Suburb	State	Postcode	
Name of Lender	Account No.		
Address of Lender			
DRIVER DETAILS			
Business name			
Address			
Suburb	State	Postcode	
Business phone	Private Phone	Mobile Phone	
Relationship to the Insured			
Licence number	Expiry Date	Date of Birth	
How many years has driver been licensed for this type of vehicle?			
Did the driver drink any alcohol or take any drugs in the 24 hours prior to the accident? If yes, give details			<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the driver undergo a breath test, breath analysis or blood test? If yes, what was the reading? Please attach copy of the certificate.			<input type="checkbox"/> Yes <input type="checkbox"/> No
			Reading:

INCIDENT DETAILS

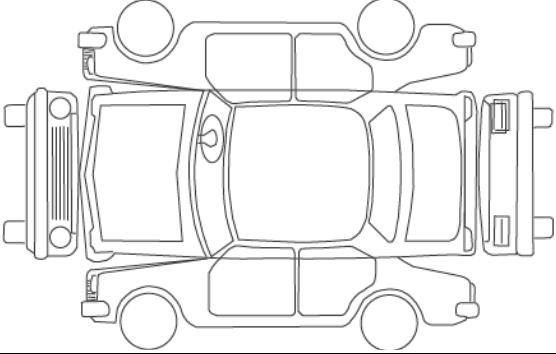
Date		Day		Time		
Where did the incident happen?						
Street		Suburb		Nearest cross st		
Road surface		<input type="checkbox"/> Dry	<input type="checkbox"/> Wet	<input type="checkbox"/> Loose		
At the time of the accident the insured vehicle was		<input type="checkbox"/> Parked	<input type="checkbox"/> Stationary	<input type="checkbox"/> Moving	Speed	
Traffic controls	<input type="checkbox"/> None	<input type="checkbox"/> Stop sign	<input type="checkbox"/> Traffic lights	<input type="checkbox"/> Roundabout	<input type="checkbox"/> Give way sign	<input type="checkbox"/> Other
Number of other vehicles involved in the accident						
If applicable, what type of goods were being transported at the time of loss?						
Description of what happened						
Who was at fault?						
Sketch diagram of accident						
1. Name streets						
2. Indicate direction of travel						
3. Your vehicle 						
4. Other vehicle 						

DAMAGE TO YOUR VEHICLE

Are you claiming for damage to your vehicle?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was the vehicle towed? If yes, give details.				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Tow company		Tow location			
Distance towed		Vehicle location now			
Sketch diagram					
Shade in damage to vehicle					
Indicate point of impact (X)					

OWNER OF OTHER VEHICLE

Business name					
Address					
Suburb		State		Postcode	
Business phone		Mobile phone		Private Phone	
Insurance company			Policy number		

DRIVER OF OTHER VEHICLE				
Name				
Address				
Suburb		State		Postcode
Divers Licence		Date of birth		Mobile phone
Was the owner in the vehicle at the time of the accident? If there is more than one other vehicle, attach details.				<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER VEHICLE				
Rego no		Year		Make
Model				Colour
DAMAGE TO OTHER VEHICLE				
<p>Sketch diagram</p> <p>Shade in damage to vehicle</p> <p>Indicate point of impact (X)</p>				
OTHER PARTIES				
Give details of pedestrians, owners of property or owners of animals involved				
Name				
Address				
Suburb		State		Postcode
POLICE DETAILS				
Did Police attend the accident scene or did you report the incident to the Police? Give details				<input type="checkbox"/> Yes <input type="checkbox"/> No
Name			Rank	
Police station			Date of report	
Crime report no.			Please attach a copy of the Police report if available.	
Name of person to be charged or cautioned				
Nature of charge or caution				
WITNESS(ES) DETAILS				
Business name				
Address				
Suburb		State		Postcode
Business phone		Private phone		Mobile phone
Was the witness in the insured vehicle?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Business name				
Address				
Suburb		State		Postcode
Business phone		Private phone		Mobile phone
Was the witness in the insured vehicle?				<input type="checkbox"/> Yes <input type="checkbox"/> No

OWNER(S) AND DRIVER HISTORY

In the last 5 years have you as the owner or the driver of this vehicle:	Had an insurance refused, declined or cancelled by an insurer or any special conditions imposed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Been convicted or charged with:	Drug use, driving under the influence or exceeding Prescribed Concentration of Alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Any driving offences or speeding infringements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Fraud, arson, theft or any other criminal act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Had a drivers or motorcycle licence cancelled, suspended or endorsed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Had a claim or accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Had a car stolen or burnt out? (include any not reported or not claimed from an insurer)		<input type="checkbox"/> Yes <input type="checkbox"/> No
Suffered or suffer from impaired eyesight (excluding wearing of glasses), loss of use of any limb or loss of hearing or from any physical defect or epileptic, diabetic, heart or mental condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If you answered yes to any of the above, please provide details below. If there is insufficient space, please attached a sheet with relevant information.

Name of driver	Date of incident	Details	Your insurer	Person at fault

PRIVACY

The Pro-Insure Privacy Policy explains what sort of personal information we collect and hold about you and what we do with that information. Please contact us for a copy of our Privacy Policy or visit our website www.proinsure.com.au

DECLARATION AND AUTHORISATION

The information and answers given above are true and complete in every detail.

I understand the claim may be refused or reduced if information is withheld.

I authorise that Pro-Insure Pty Ltd give to and obtain from other insurers, insurance reference bureaus and credit agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Signature of Insured 1.		Name	Date
Signature of Insured 2.		Name	Date

Please check that this form has been fully completed as any omissions may delay your claim.

PRINT FORM

RESET FORM