Motor vehicle claim form

### IMPORTANT

* + - Fully complete this form, where applicable, to ensure prompt attention.
    - If there is not enough space for your answer in any section, please write the details on a separate sheet of paper.
    - Do not admit liability to, or offer to pay any expenses of, a third party.
    - Forward any communications you receive from a third party to this office.
    - Forward any statements from witnesses and/or employees to this office.
    - Please attach all quotations for the repair of the insured vehicle, together with any correspondence or quotations received from any third party.
    - This form to be completed for any property damage to the VMIA insured entity’s own vehicle and/or any third party property damage and returned to: Victorian Managed Insurance Authority  
      PO Box 18409, Collins St East, Melbourne 8003 OR Fax 9270 6911 OR Email [claims@vmia.vic.gov.au](mailto:claims@vmia.vic.gov.au)

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| Insured’s details |
| VMIA insured entity’s name: |
| Contact person: |
| Address: |
| Telephone: |
| Fax: |
| Email: |
| Are you registered for GST purposes?  If yes, what is your ABN: |
| Have you claimed an input tax credit on the GST applicable to this policy?  Yes  No  If yes, specify the percentage amount claimed:      % |

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| Description of the insured vehicle involved in the accident |
| Registration number: |
| Make: |
| Model: |
| Year of manufacture: |
| Body type: |
| Was there any unrepaired damage to the vehicle before the accident? Yes  No  If yes, please describe any unrepaired damage: |
| Is your vehicle damaged? Yes  No  If so, If so please shade the appropriate area on the diagram below to highlight where your vehicle is damaged |

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| Driver details |
| Who was driving the insured vehicle when the accident happened? |
| Driver’s address: |
| Contact telephone numbers:  Private:  Business: |
| Occupation: |
| Drivers licence number:  Expiry date:      /     /  Class: |
| DOB:      /     / |
| Was this person driving with the knowledge and consent of the insured? Yes  No |
| Did the driver drink any alcohol, take drugs or medication in the 12 hours prior to the accident? Yes  No |
| State the details including what was taken, when it was taken and how much was taken: |
| Has the driver been charged with or convicted of a motoring offence (other than a parking offence) or been disqualified from driving in the past 5 years? Yes  No  If yes, please state the details: |
| Has the driver been charged with or convicted of, any criminal offences in past 10 years? Yes  No  If yes, please state the details: |
| Has the driver had insurance refused or cancelled, had a renewal refused or had special conditions imposed by an insurer? Yes  No  If yes, please state the details: |

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| Description of accident |
| Date of accident:      /     / |
| Time of accident: |
| Where did the accident happen? |
| What were the road conditions at the time of the accident? |
| What were the weather conditions at the time of the accident? |
| Was either driver facing traffic lights, a stop, a give way or any other signs at the time of the accident?  Yes  No  If yes, please state the details: |
| What happened? (Describe in detail how the accident occurred and all the facts even if they are not in your favour. A schematic diagram may assist our understanding) |
| At the time of the accident what was the approximate speed before braking of the:  Insured vehicle?       km/h  Other vehicle?       km/h |

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| Description of the other vehicle involved in this accident |
| Full name of the vehicle owner: |
| Address: |
| Owner’s insurance company: |
| Registration number: |
| Make: |
| Model: |
| Year of manufacture: |
| Body type: |
| Who was driving the other vehicle when the accident happened? |
| Address: |
| Contact telephone numbers:  Private:  Business: |
| Drivers licence number:  Expiry date:      /     /  Class: |
| DOB:      /     / |
| Is the other vehicle damaged? Yes  No  If so, please shade the appropriate area on the diagram below to highlight where the other vehicle is damaged |
| Where there any witnesses to the damage / loss? Yes  No  If yes, please provide the witness name, address and telephone number: |
| Was there damage to or loss of any property of a third party? Yes  No  If yes, provide description of items damaged, extent of damage and, if possible, approximate cost of repair or replacement: |
| Did the police or fire brigade attend the accident? Yes  No  If no, was the accident reported to a police station? Yes  No  If so, please advise the officer’s name and the name of the station. |
| Was either driver charged with an offence(s) or advised that charges may be laid?  Yes  No  If so, please provide details: |

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| Driver declaration |  |
| Name:  Signature: ………….……………………………………….  Position: | Date:      /     / |

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| Authorised Officer’s declaration |  |
| Name:  Signature: ………….……………………………………….  Position: | Date:      /     / |
| I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.  I consent to the VMIA using personal information I have provided on this form for the purpose of assessing any future claims that may arise in relation to this notification. However, I understand that if I choose not to provide the required details, this is my choice and that the VMIA may not be able to assess any future claims.  I consent to the VMIA disclosing personal information to other insurers or as required by law. I consent to the VMIA also disclosing personal information to and/or collecting additional information from investigators, legal advisers, medical advisers or other advisers whom the VMIA may engage to assist in processing any future claims. Where I have provided information about another individual (e.g. an employee or client) I declare that the individual has been made aware of the reason for the disclosure of their personal details to the VMIA and of the contents of the VMIA's Privacy Policy. | |
| Signature of the Insured or person with authority to sign for and on behalf of the Insured. | |
| Name:  Signature: ………….……………………………………….  Position: | Date:      /     / |

Any personal information you provide directly (or provided by a health service under s141 of the Health Services Act 1988, or a third party such as a government body) in this Form is being collected by the VMIA for the purpose of administering VMIA’s functions, under s6 of the Victorian Managed Insurance Authority Act 1996 (Vic), namely to provide insurance, risk advisory and claims handling services. Any personal information you provide will be treated according to the requirements of the Privacy and Data Protection Act 2014 (Vic), the Information Privacy Principles, the Victorian Protective Data Security Standards, the Health Records Act 2001 (Vic) and the Health Privacy Principles. VMIA will not act or engage in any practice that contravenes these provisions. Information will be handled in line with VMIA's Privacy Policy. You have the right to access and correct your personal information. Requests for access should be sent to the Privacy Officer, VMIA, PO Box 18409, Collins Street East, VIC 8003 or privacy@vmia.vic.gov.au.