

MOTOR VEHICLE CLAIM FORM

We're sorry to hear you've had an accident. Our aim is to facilitate the ease of the claims process so your claim can be assessed as quickly as possible.

You can help us do this by ensuring the enclosed claim form is completed promptly and that all questions are fully answered. If there is insufficient space, please attach a separate statement.

The completed claim form should be forwarded to us as soon as possible together with the details of your preferred repairer. The Insurers website may have a list of panel repairers available that is closest to you.

The information provided below may answer some of the questions which could arise following your claim:

- If requested, the excess must be paid either to the repairer when you collect your vehicle or to the Insurers by way of an excess request. You may be requested to pay this by the Insurers even if you were not at fault. If the accident was clearly someone else's fault, the Insurers will take recovery action against the person responsible for the accident and will include the amount of your excess in their recovery action.
- If the other party involved in the accident has stated that you are being held responsible for the damage to the other vehicle or property, you should indicate that you will be lodging a claim with us and that any demands for compensation will be handled by your Insurer. Do not admit liability or make any offers or promises of payment without our consent.
- If you receive a letter of demand and a quotation and/or account for the repairs to another person's vehicle or property, you must send this correspondence to us immediately. Any delays could result in additional costs.
- Even if you feel you were not responsible for the accident, do not ignore letters of demand from the other party. Any correspondence from the other party should be forwarded to us. If you fail to act on the other party's letter of demand, it may result in a summons being served on you. If this happens, you must contact us immediately.

Should you have any problems during the period of your claim, please contact us and quote your claim number if you know it. We assure you of our prompt attention to any queries you may have.

PLEASE RETURN COMPLETED CLAIM FORM AND ANY SUPPORTING DOCUMENTATION TO:
mpclaims@midlandinsurance.com.au

YOUR PRIVACY

The Privacy Act 1988 requires us to make the following disclosure before collecting personal information about you:

- We collect personal information in order to provide our broking services including assistance with insurance claims. We will ask you to supply personal information on this form so we can assist you to submit your insurance claim and have it considered by the insurer. We will disclose this information to the insurer for this purpose.
- If the personal information is not provided, the insurer may not be able to assess and pay the claim and we may not be able to assist with your claim.
- We and the insurer may disclose the personal information to other people involved in reviewing the claim, including reinsurers, other insurance intermediaries, the insurer's advisors such as loss adjusters, lawyers and accountants, and other parties involved in the claims handling process.
- Your information will be disclosed to organisations overseas if your policy is underwritten by an overseas insurer. If your insurer is overseas, you can contact us for information about where the insurer is located.
- By signing this form, you consent to us and the parties mentioned above collecting, using and disclosing personal and sensitive information about you for the purposes described above. You understand that any personal and sensitive information disclosed to organisations located overseas may not be protected in the same way as it is in Australia. Even though we have no control over how the information will be used and disclosed, you consent to us disclosing your personal and sensitive information to those overseas organisations for the purposes described above.

Further information about how to access the personal information we hold about, have it updated or corrected or how to make a complaint about how your personal information is in our Privacy Policy on our website:

https://midlandinsurance.com.au/wp-content/uploads/2020/08/Privacy-Statement-and-Compliance-doc_15.01.2020.pdf

Claim Number: 1.

PLEASE RETURN COMPLETED CLAIM FORM TO: mpclaims@midlandinsurance.com.au

Policyholder

Full Name and Address of Policyholder	Occupation: Telephone Numbers: Business Hours (.....) After Hours (.....)	
Insurer:	Policy No:	Expiry Date: / /
For what purpose was the vehicle being used?		

2. Insured Vehicle

Make & Model:	.....
Body Type:	Year of Manufacture:
.....
Registration No:	Engine No:
.....
V.I.N. No:	Expiry Date of Registration:
..... / /
Name & Address of Finance Co. (if applicable)	
.....	
.....	
Have there been any engine, body or transmission modifications from the manufacturer's original specifications or any accessories added?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please give details:</i>	

3. Driver (Please complete these details in respect of the person in charge of the vehicle at the time of the accident)

Full Name of Driver Address of Driver Contact Telephone No.		Occupation: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: / /	
Drivers Licence No:		Licence Class	
How long has the driver held a motor vehicle drivers licence? years		Expiry Date of Licence: / /	
Was the vehicle being used with the full knowledge and consent of the policyholder? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is the relationship of the Driver to the Policyholder? <input type="checkbox"/> Self <input type="checkbox"/> Relative <input type="checkbox"/> Employee <input type="checkbox"/> Friend <input type="checkbox"/> Other If Other, please describe:			
Have you (the Policyholder) or the driver of the vehicle at the time of the accident: (i) been involved in any previous motor vehicle accident in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (ii) been charged with any offence in relation to the use of a motor vehicle in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (iii) had any insurance declined or cancelled, been refused renewal of an insurance or had special terms imposed in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", to (i), (ii) or (iii), please give details below:			
Name	Date	Particulars (eg, name of insurance company, details of charges etc)	

Was the driver under the influence of any drug or alcohol at the time of the accident?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please state what drugs or how much alcohol was consumed by the driver in the 12 hours prior to the accident:	
Did the driver undergo a breath test?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what was the reading?
Has the driver's motor vehicle licence ever been cancelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give details:	

4. Accident Date

Date of accident: / /	Time of accident:	am	pm
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5. Description of Accident









Name of street where accident occurred
If at an intersection, names of intersecting streets
Suburb, Town, City	.....
State clearly and fully how the accident occurred (if insufficient space, attach separate statement)	
Was the street wet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the other party admit liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give details:

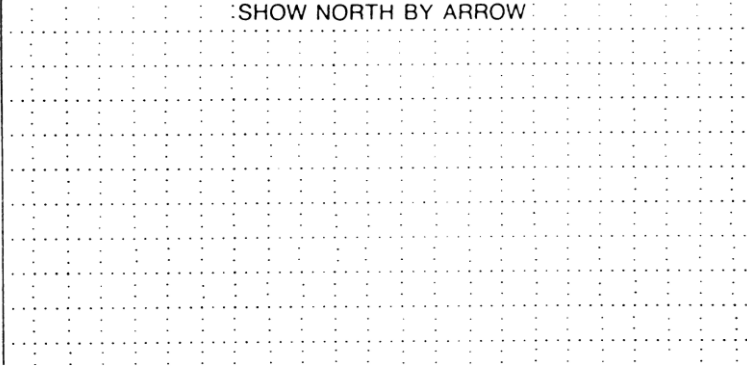
Please draw sketch showing position of all vehicles and pedestrians at the time of the accident:

Please draw Sketch showing position of all Vehicles and Pedestrians at the time of the accident. Show also position of all Traffic Lights, Signs, and Pedestrian Crossings.

SHOW NORTH BY ARROW

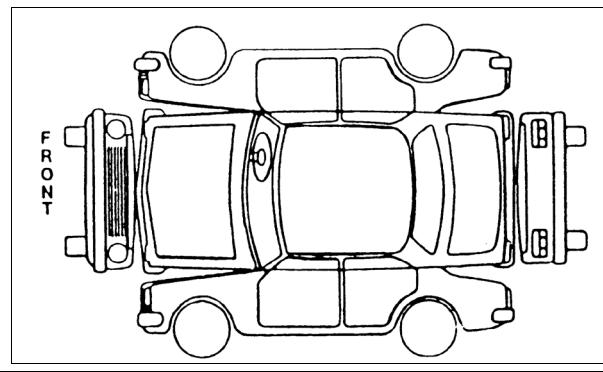
SYMBOLS

- | | | | |
|---------------------|---|----------------|---|
| Street Intersection |  | Pedestrians |  |
| Curved Street |  | Stop Sign |  |
| Your Vehicle |  | Give Way Sign |  |
| Other Vehicle |  | Traffic Lights |  |



Did the driver suffer any injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, was medical attention required? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, state name and address of doctor or hospital
Please indicate Insured Vehicle's speed immediately prior to accident	<input type="checkbox"/> Stationary <input type="checkbox"/> Under 30 km/h <input type="checkbox"/> 30-60km/h <input type="checkbox"/> 60-80km/h <input type="checkbox"/> 80-100km/h <input type="checkbox"/> Over 100km/h
Please indicate Other Vehicle's speed immediately prior to accident	<input type="checkbox"/> Stationary <input type="checkbox"/> Under 30 km/h <input type="checkbox"/> 30-60km/h <input type="checkbox"/> 60-80km/h <input type="checkbox"/> 80-100km/h <input type="checkbox"/> Over 100km/h
Was the vehicle towed from scene of accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please give name of towing contractor
Did you authorise this towing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Present location of the vehicle	.....
Please advise your repairer of choice. (Name of repairer and address )	.....
Estimated Cost of Repairs (including parts)	\$ Repair Quotation No:

Please indicate areas of damage to insured vehicle



6. Police

Date reported to Police	..... / ..... / .....	Time reported to Police	am	pm
Did the Police attend the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: i From which Police Station? ii Name of Officer iii Event Number			
Did the Police indicate which driver was at fault?	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please state: (i) Name of driver charged or cautioned (ii) Nature of charge or caution			

7. Other Parties (Please complete this section if any other vehicles or property involved)

Number of other vehicles involved	.....
Owner's name	.....
Owner's Address	..... State: Postcode:	
Driver's name	.....
Driver's Address	..... State: Postcode:	
Telephone No.	.....
Licence Number	.....	Age:
Make and Model of Vehicle	.....
Registration Number	.....

Describe damage to other party's vehicle and/or property <i>NB: (If more than one third party involved, please provide similar particulars on a separate sheet)</i>	
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8. Witnesses

Passengers in Insured Vehicle	
Names	Addresses
Independent Witnesses	
Names	Addresses

9. ABN Details

Are you a registered business?	Yes <input type="checkbox"/> No <input type="checkbox"/>	What is your ABN number?
What percentage of GST in your premium did you claim as an Input Tax Credit for the period of insurance in which this loss occurred?%		

10. Declaration

The information and answers given above are a true and complete statement of the facts and matters relating to the happening for which this claim is made, and no information likely to affect this claim has been withheld. I authorise my Insurer to undertake on my behalf whatever actions are necessary to indemnify me within the terms of my policy including if necessary, removal of my vehicle to alternative premises to enable repairs to be carried out by a qualified Motor Body Repairer. I understand that this claim may be refused if information is untrue, inaccurate or concealed.

I expressly agree that the information given by me is provided with my full knowledge and consent and further agree to hold harmless and indemnify Midland Insurance Brokers in the event of any action or matter that may be taken by any party pursuant to the Privacy Act 1988 (Cth). I/we acknowledge that I/we have read and understood the paragraphs accompanying this proposal headed "Your Privacy".

Driver's Signature Date: / /

Policyholder's Signature Date: / /