



DOMINION
INSURANCE

Motor vehicle insurance claim form

Nuku'alofa: Patco Building, Taufa'ahau Road

Phone: (676) 21105

Fax: (676) 25143

Important Notes

- To assist Dominion Insurance (Tonga) Limited (“us/our/we”) process your motor vehicle claim kindly ensure your claim form is correctly completed in particular the following must be **fully supplied**:
 - ✓ Driver to sign claim form and provide a copy of the licence
 - ✓ You the Insured to sign the claim form
 - ✓ Copy of 2x repair quotations from repairers approved by Dominion
 - ✓ Copy of any demand(s) made by other parties for their vehicle and/or property
 - ✓ Full details of any persons (names, addresses) suffering personal injury or injury
 - ✓ Copy of witness statements
 - ✓ Provide copy of detailed Police Report
 - ✓ Copy of temporary repairs/towing invoices
- Repairs must not be authorised without our approval. If we elect to repair your vehicle, you may use the repairer of your choice. However we will not pay more than our assessor’s estimate of the cost of repairs.
- Any salvage belongs to us and **MUST** not be disposed of without our permission. If salvage is disposed without our permission or is unaccounted for, your claim may be reduced by the value of the salvage.
- If anyone holds you responsible for damage to their vehicle or property ask for their claim to be in writing and to include two quotations for repairs and send it to us.
- If the vehicle is unable to be driven and is at a repair shop, leave the completed claim form with us.
- You must immediately notify the Police unless the event is a broken windscreen or where the claim does not exceed \$2,000.
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- You may be called upon to pay any excess applicable under the Policy, whether you were at fault or not. We will try to recover this money for you.
- If the other party is at fault, keep a record of any other costs which you might have to personally pay as a result of the accident, and we will always endeavour to recover these for you.
- Discuss any problems or concerns you have with us.

Motor insurance claim form

Policy No.	<input type="text"/>	Claim No.	<input type="text"/>
Insurance period from:	<input type="text"/>	To:	<input type="text"/>
Insurance premium:	\$ <input type="text"/>	Date paid:	<input type="text"/>
		Receipt number: <input type="text"/>	

POLICY HOLDER DETAILS

Full Names: Mr. Mrs. Ms	<input type="text"/>	Surname:	<input type="text"/>
Address:	<input type="text"/>	Occupation:	<input type="text"/>
Contact Numbers	Home <input type="text"/>	Bus: <input type="text"/>	Mob: <input type="text"/>
		Fax: <input type="text"/>	Email: <input type="text"/>
Occupation:	<input type="text"/>		

VEHICLE DETAILS

Make:	<input type="text"/>	Model:	<input type="text"/>	Type: Car, Van etc:	<input type="text"/>
Registration number:	<input type="text"/>	Year:	<input type="text"/>	Purchase date:	<input type="text"/>
Purchase price:	<input type="text"/>	Purchased from:	<input type="text"/>		
Modified: Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes state details: <input type="text"/>				
Name of any party with financial interest:	<input type="text"/>				

DRIVER DETAILS

Given Names:	Mr. Mrs. Ms <input type="text"/>	Surname:	<input type="text"/>
Address:	<input type="text"/>	Occupation:	<input type="text"/>
Date of Birth	<input type="text"/>	Relationship to insured:	<input type="text"/>
Type of licence:	<input type="text"/>	Classes covered:	<input type="text"/>
		Licence number:	<input type="text"/>
		Expiry date:	<input type="text"/>
Do you own your own vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of insurance company: <input type="text"/>		

1. Details of any intoxicating liquor or drug (prescribed or otherwise) taken by you in the 12 hours prior to the accident. (If none state nil)

2. Have you had a policy of insurance cancelled, declined or an excess or increased premium imposed? Yes No If Yes give details below

3. Have you ever had your drivers licence endorsed or suspended? Yes No If Yes give details below

4. Have you incurred any Traffic Offences (other than parking within the last 5 years? Yes No If Yes give details below

Approx date	Offence(s)	Action
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Detail all motor accidents (other than windscreen breakage) that you have been involved in the last 5 years. (If none state nil)

Approx Date	Details	Insurance Company
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

6. Did the Police attend the accident? Yes No If Yes give details below

Officers name & number	<input type="text"/>	Station	<input type="text"/>
	<input type="text"/>		<input type="text"/>

7. Was any person required to complete a blood/breath test? Yes No If Yes give details below

Name	Type of test	Results
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

OTHER PARTY DETAILS					
Name:					
Address:					
Contact Numbers	Home:	Bus:	Mob:	Fax:	Email:
Vehicle Details:		Make:	Model:	Reg No.	
Details of Damage:					
Insurance Co:					

DETAILS OF INJURED PERSONS - PERSON 1					
Name:					
Address:					
Vehicle Reg:					
Age:		Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Contact Numbers	Home	Bus:	Mob:	Fax:	Email:
Describe Injury:					
Was person wearing seat belt or crash helmet as appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/>					

DETAILS OF INJURED PERSONS – PERSON 2					
Name:					
Address:					
Vehicle Reg:					
Age:		Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Contact Numbers	Home	Bus:	Mob:	Fax:	Email:
Describe Injury:					
Was person wearing seat belt or crash helmet as appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/>					

DETAILS OF INJURED PERSONS – PERSON 3					
Name:					
Address:					
Vehicle Reg:					
Age:		Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	
Phone:	Home	Business:	Mobile:		
Describe Injury:					
Was person wearing seat belt or crash helmet as appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/>					

