



Comcover Motor Vehicle Claim Report

Section A Fund Member Name

**Fund
Member
Details**

Details of person within Fund Member to contact concerning the claim:

Name	<input type="text"/>
Business Address	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>
Date that you or your entity first became aware of the claim	<input type="text" value="/"/> <input type="text" value="/"/>

Section B

**Driver
Details**

Name of Driver	<input type="text"/>		
Date of Birth	<input type="text" value="/"/> <input type="text" value="/"/>		
Business Address	<input type="text"/>		
Telephone	<input type="text"/>		
Email:	<input type="text"/>		
Licence Number	Expiry Date:	<input type="text" value="/"/> <input type="text" value="/"/>	
Is the driver named above the principal driver?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the driver consume any alcohol or take any drugs within 12 hours prior to the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did the Police perform a breath or blood test?	<input type="checkbox"/> Yes, if so please state the reading below <input type="checkbox"/> No		

Section C

**Member
Vehicle
Details**

Please indicate the cover that applies to you/vehicle

- ☐ Comprehensive (repairs to your vehicle **are** covered under the policy)
☐ Third Party Property damage only (repairs to your vehicle **are not** covered under the policy)

Vehicle Registration Number	<input type="text"/>			
Make	Model	Year	<input type="text"/>	
Number of occupants (including the driver) at the time of the incident	<input type="text"/>			

Section D
**Accident
Details**

Date of accident	<input type="text" value="/"/> <input type="text" value="/"/>	Time:	<input type="text"/>
Location of accident	<input type="text"/>		
Was anyone injured?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If, so in which vehicle and type of injury?	<input type="text"/>		
Was it reported to the Police?	<input type="checkbox"/> Yes if so give details below <input type="checkbox"/> No		
Police Station	<input type="text"/>		



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Officer Name
Police Station Phone No.
Police Incident No.
Is Police action to be taken?
If so, against whom?
Who do you think is
responsible for the accident?
Any other details?

<input type="checkbox"/> Yes	<input type="checkbox"/> No

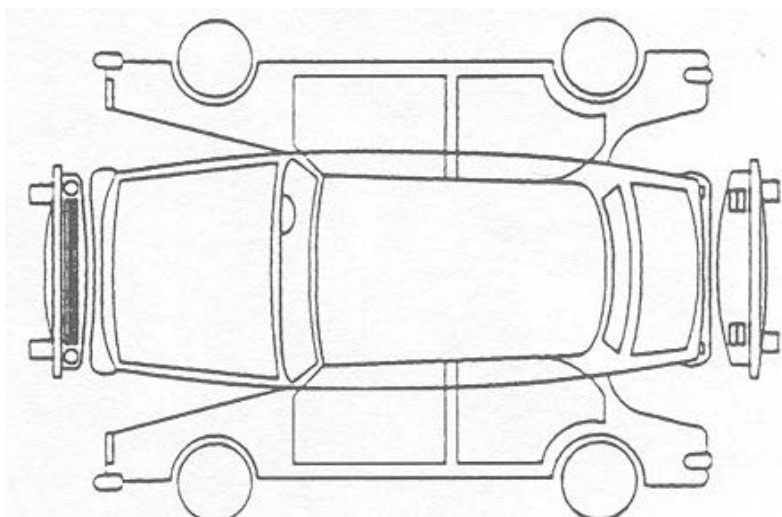
Section E

Other Vehicle Driver Details

Name of Driver
Date of Birth
Residential Address
Telephone
Email
Licence Number
Name of registered vehicle
owner
Address of registered
vehicle owner
Telephone
Vehicle registration number
Insurer

/ /	
	Mobile No.
	Expiry Date: / /
	Make and Model

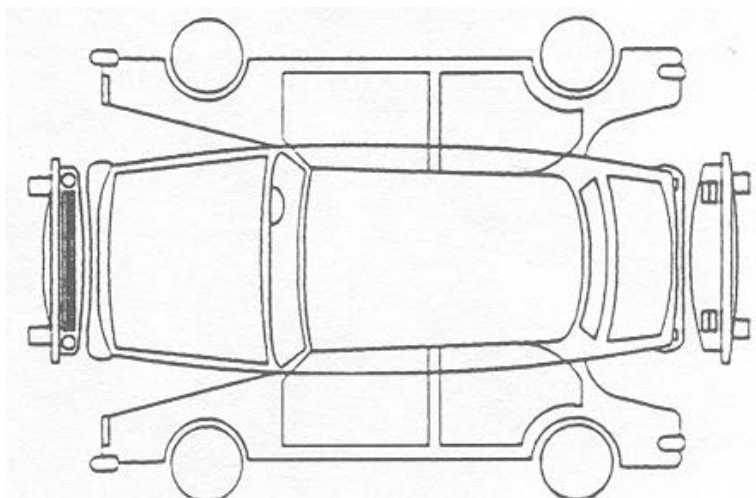
Show
damage to
member
vehicle



Show
damage to
other
vehicle



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**Accident
Description**

Please provide a brief description of how the accident occurred

Please draw a diagram of accident at point of collision

Section F

Witness

Witness to accident (attach list if necessary)

Name

Address

Telephone

Driver's Declaration

I declare that the use of the vehicle was authorised and the information provided in this claim form is correct in every respect

Driver's Name

Signature

Date



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Attachments

- One quote for repair to member vehicle
- Police Report (if available)

Failure to provide these items may result in a delay in managing your claim.

In accordance with the Privacy Act 1988 and the Australian Privacy Principles, all personal and sensitive information collected directly from you, and from other agencies, will be stored and used on our claims management system. This information may be forwarded to external service providers for the purposes of assessing your claim, and may be shared with third parties as authorised by law. Further information about the privacy practices of Finance, including how to make a complaint, is contained in the privacy policy available at <http://www.finance.gov.au/sites/default/files/privacy-policy.pdf>.

Name of person reporting the claim

Signature of person reporting the claim

Date

Name of Fund Member Insurance Contact

Signature of Fund Member Insurance Contact

Date