

### THIRD PARTY ACCIDENT/LOSS REPORT FORM

**CLAIM NO.:**

NAME OF OWNER / CLAIMANT:		VEHICLE NO.:
ADDRESS:		MAKE OF VEHICLE:
PROFESSION / OCCUPATION:		PHONE NO.:
EMPLOYER:	ADDRESS:	
NAME OF INSURANCE COMPANY:		
TYPE OF COVERAGE:	POLICY NO.:	EXPIRY DATE:
EMAIL (WK):	(H):	VAT NO.:

#### DRIVER

NAME OF DRIVER:		DATE OF BIRTH:
ADDRESS:		PHONE NO.:
PROFESSION / OCCUPATION:		PERMIT NO.:
DATE OF ISSUE:		EXPIRY DATE:
DOES DRIVER OWN A VEHICLE:	YES <input type="checkbox"/> NO <input type="checkbox"/>	VEHICLE NO.:

#### GUARDIAN GENERAL INSURANCE CLIENT / INSURED

CLIENT'S NAME:		VEHICLE NO.:
DRIVER'S NAME & ADDRESS:		
DATE OF ACCIDENT / LOSS:		TIME:
LOCATION OF ACCIDENT / LOSS		
ADDRESS OF POLICE STATION:		DATE REPORTED:
NAME OF OFFICER / NUMBER:		

#### DETAILS OF ACCIDENT / LOSS


#### SKETCH OF ACCIDENT / LOSS

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#### WITNESSES (IMPORTANT)

NAME	ADDRESS	PHONE NO.

#### INJURY TO PERSONS

NAME	AGE	ADDRESS	NATURE OF INJURIES

\_\_\_\_\_  
**SIGNATURE OF CLAIMANT**

\_\_\_\_\_  
**DATE**