



THE INSURANCE COMPANY OF THE WEST INDIES LIMITED

2 St. Lucia Avenue, Kingston 5, Tel: 926-9040-7, 926-9182-91, Fax: 929-6641

MOTOR VEHICLE CATASTROPHE CLAIM FORM

I hereby declare that all particulars to be given are true and correct and that no false or fraudulent statement will be made _____

NOTE: "N/A" means "Not Applicable"

Insured's Signature

THE INSURED

Name: _____ Mr/Mrs/Miss: _____

Address: _____

Telephone Nos: Work: _____ Home: _____ Cel: _____

Fax No: _____ Email: _____

PARTICULARS OF VEHICLE

Year: _____ Make: _____ Model/Type: _____ Policy No: _____

Colour: _____ Registration No: _____ Value: \$ _____

Mortgage Interest and Address: _____

THE INCIDENT

Date of Loss: _____ Is vehicle drivable: Yes No

Extent of Damage (briefly describe the damage that appears to have been sustained by the vehicle) _____

Location of vehicle: _____

I/We hereby declare that the foregoing particulars given by me/us have been read over and found to be true and correct in every respect, and I/we agree that if I/we have made, or in any further declaration the Company may require in respect of the said accident shall make, any false or fraudulent statement, or if found guilty of any suppression or concealment, the policy shall be void and all rights to recover thereunder in respect of past or further accidents, shall be forfeited.

Signature of Insured: _____ **Date:** _____

Signature of person reporting the claim: _____ **Date:** _____

OFFICE CHECKLIST

Policy Period : From: _____ **To:** _____

Premium Paid: Yes No **Comprehensive Cover:** Yes No

Assessor Appointed: Yes No **Name of Assessor:** _____
(please print)

Name of Broker/Agent: _____

Claim No: _____

Remarks: _____