

My Motor Claim[®]

ACCIDENT MANAGEMENT

T: 03 9363-8865 | M: 0411 322 907

E: claims@mymotorclaim.com.au | W: www.mymotorclaim.com.au

Claim Form

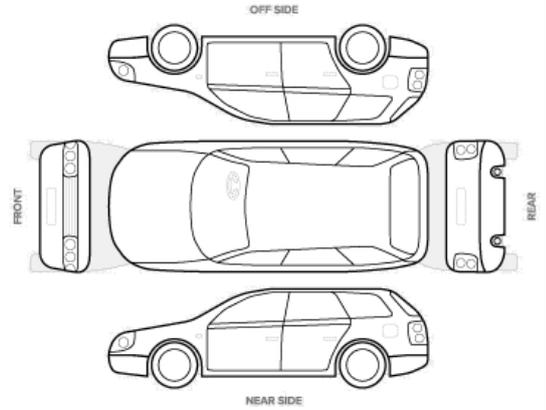
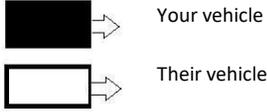
CLIENTS DETAILS			
Vehicle Owner Surname:		Vehicle Owner First Name: Mr/Mrs (please circle one)	
Driver Surname:		Driver First Name: Mr/Mrs (please circle one)	
Address:			
Phone:	Email:	License number:	
VEHICLE DETAILS			
Make:	Model:	Year:	Registration:
Registered for GST? (please tick one) YES <input type="checkbox"/> NO <input type="checkbox"/>			

AT FAULT PARTY DETAILS			
Surname:		First Name:	
Address:			
Phone:	Email:	License number:	
VEHICLE DETAILS			
Make:	Model:	Year:	Registration:
INSURANCE DETAILS			
Insurer		Claim number	

ACCIDENT DETAILS	
Date of loss/Accident & Location:	Approx. time:

Version and Diagram

Accident diagram



Please shade damaged areas

Please provide a brief description:

INDEPENDENT WITNESS DETAILS

Full name:

Contact number:

Email address:

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Authority to Act

Name _____

Mailing Address _____

Contact Number _____

Email Address _____

To _____

Claim no/Ref no _____

I/We the undersigned, hereby authorise My Motor Claim to act on my/our behalf in all matters relating to my/our motor vehicle accident claim including discussing, obtaining, and signing of all documents relating to this matter.

Signed: _____

Dated: _____

D-Collect and Associates Pty Ltd Trading as My Motor Claim

ABN 27 609 517 688