

Heritage MotorCover Claim Form

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CUSTOMER INFORMATION

Name of Insured:		Policy Number:	
Agent (if any):			
Telephone	(Home):	(Work):	
	(Mobile):	Email:	

INSURED VEHICLE

Year:	Make:	Model:	Registration:
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Vehicle Accessories on the vehicle at the time of the accident:	Value:

Has the vehicle, its engine or wheels been modified in any way since manufacture?: Yes No
If 'Yes', please provide full details:

Is the vehicle subject to any finance?: Yes No
If 'Yes', name of finance company:

THE DRIVER

Who was driving or in charge of the vehicle at the time of the accident?

Name:

Address: (if different to above)

Date of birth (DD/MMM/YYYY):

Relationship to insured:

Driver's license number: **Type:**

Issued: **Expires:**

Does the driver have motor vehicle insurance with another insurance company?: Yes No
If 'Yes', please provide full details:

Heritage MotorCover Claim Form

THE ACCIDENT

Driver to complete

What was the time: AM PM and date: _____ of the Accident?

Where was the location of the accident?: _____

What was your speed at the time of the accident?: _____ mph kph

Were your headlights on?: Yes No

What were the weather conditions at the time of the accident?: _____

What warning was given immediately prior to the accident?: _____

Were you able to drive your vehicle?: Yes No If 'No', who towed it?: _____

Where is the vehicle now?: _____

Please explain exactly how the accident occurred (if insufficient room, please continue on a separate sheet of paper): _____

DIAGRAM

Please complete a diagram showing clearly:

- Direction travelling and where each vehicle was prior to accident
- Point of impact - marked with an "X"
- Names of all streets, and location of any traffic lights, 'Stop' or 'Give Way' signs, etc.

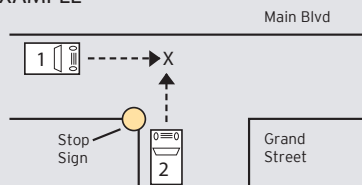
Your vehicle



Other vehicle



EXAMPLE



Heritage MotorCover Claim Form

THE ACCIDENT (continued)

Driver to complete

Do you believe anyone else to be at fault in this accident?: Yes No

Did the Police witness or attend the scene of the accident?: Yes No

If 'Yes', name of Police Officer: _____ Report Number: _____

Address of Police Station: _____

Was the driver or any passenger(s) in YOUR vehicle injured as a result of this accident?: Yes No

Name (1): _____ Age: _____

Address (if different to above): _____

Nature and extent of injuries: _____

Name (2): _____ Age: _____

Address (if different to above): _____

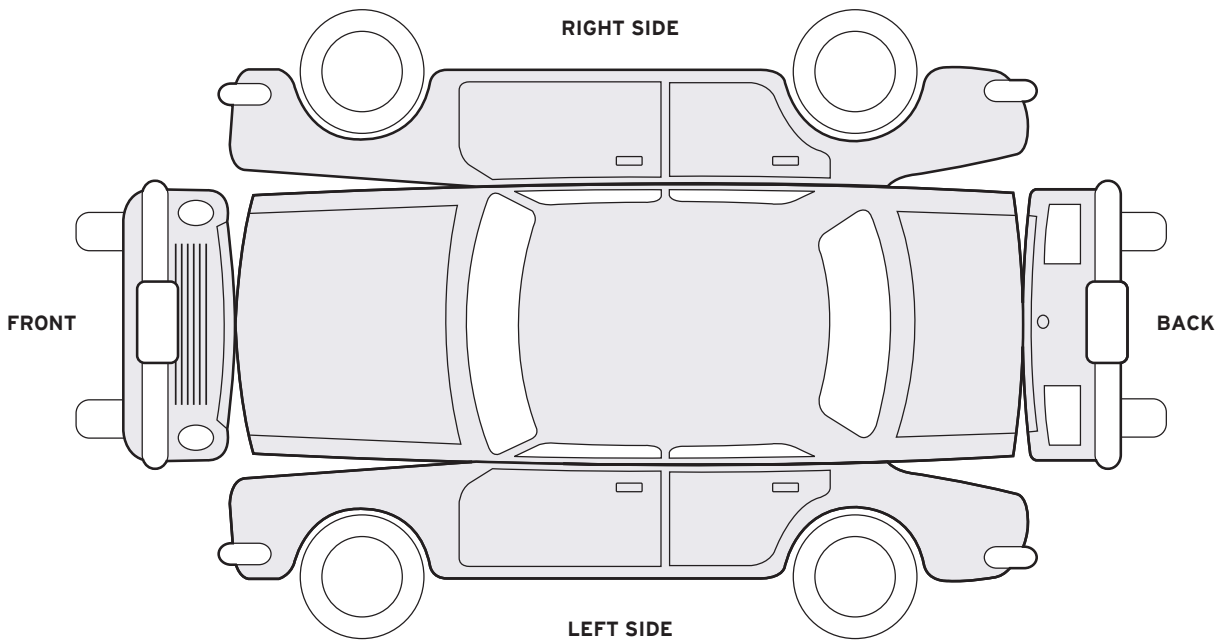
Nature and extent of injuries: _____

Was the injured person(s) taken to the hospital?: Yes No

If 'Yes', Attending Doctor's name: _____

Name of Hospital: _____

Please illustrate damage to your vehicle by indicating an X on the diagram below:



Heritage MotorCover Claim Form

PERSONAL INJURY TO THIRD PARTIES

Was anyone else injured as a result of this accident?:

Yes

No

Name (1):

Age:

Address:

Nature and extent of injuries:

Name (2):

Age:

Address:

Nature and extent of injuries:

Was the injured person(s) taken to the hospital?:

Yes

No

If 'Yes', Attending Doctor's name:

Name of Hospital:

WITNESSES

Please provide names and contact details of all witnesses to this accident.

Name (1)

Telephone:

Address:

Name (2)

Telephone:

Address:

Name (3)

Telephone

Address:

THIRD PARTY DETAILS

Name of Owner:

Name of driver:

Telephone (Home):

(Home):

(Work):

(Work):

(Mobile):

(Mobile):

Email:

Email:

Vehicle Year:

Make:

Model:

Registration:

Is there any third party property damage?:

Yes

No

If 'Yes', what is the extent of the damage?:

Third Party's Insurer:

Policy number:

Did the other driver admit liability for the accident?:

Yes

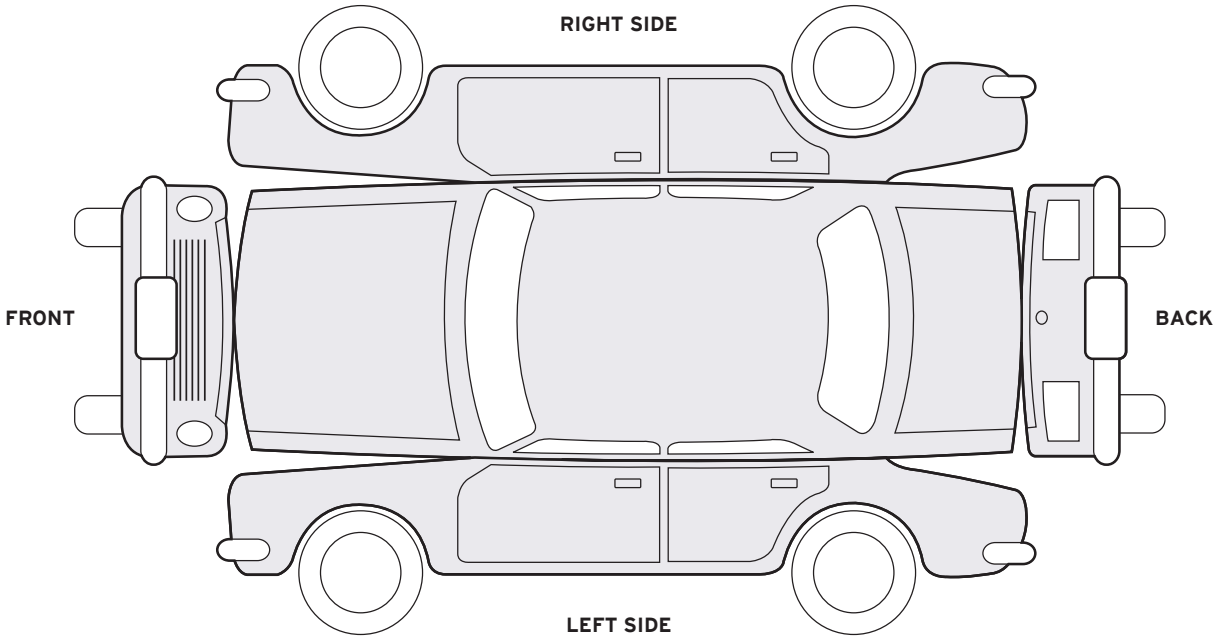
No

Provide details of any conversations:

Heritage MotorCover Claim Form

THIRD PARTY DETAILS (continued)

Please illustrate damage to your vehicle by indicating an X on the diagram below:



TO BE COMPLETED BY INSURED

Please answer all questions fully

- | | | | |
|----|--|------------------------------|-----------------------------|
| 1. | Have you been convicted in the last 5 years of any offence in connection with any motor vehicle, or is any prosecution or Police enquiry pending?:
If 'Yes', please provide full details: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. | Have you made any claims or been in an accident in connection with a motor vehicle in the last 5 years?:
If 'Yes', please provide full details: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. | Was your vehicle being driven without your authority or permission?
If 'Yes', please provide full details: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. | Was the vehicle being used for other than private use?:
If 'Yes', please provide full details: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. | Is there any other insurance on the vehicle?:
If 'Yes', please provide full details: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Heritage MotorCover Claim Form

TO BE COMPLETED BY DRIVER

1. Had you consumed any intoxicating liquor or taken any medication or other drugs within 6 hours prior to the accident? Yes No
If 'Yes', please provide full details:
2. If you are not the insured, do you have a vehicle of your own? Yes No N/A
3. Have you been convicted in the last 5 years of any offence in connection with any motor vehicle, or is any prosecution or Police enquiry pending? Yes No
If 'Yes', please provide full details:

ISLAND HERITAGE'S DATA PROTECTION DECLARATION

I/We confirm/understand that:

- I/We consent to Island Heritage and the BF&M Group processing my personal data in accordance with Island Heritage's privacy policy in full at www.islandheritageinsurance.com/privacy.
- I/We understand that I/we may withdraw my consent at any time by email to privacy@bfm.bm but that may impact Island Heritage's ability to provide insurance or pay claims.
- I/We confirm that any personal data I/we provide to Island Heritage in respect of any third party, is done with that third party's consent and knowledge of Island Heritage's processing of their personal data.

Insured's Signature: _____ Date (DD/MMM/YYYY): _____

Driver's Signature: _____ Date (DD/MMM/YYYY): _____

DECLARATION

I/We declare that:

- All the statements in this claim form and any additional schedules are true and accurate;
- The Motor vehicle and/or accessories are correctly described in this form and were damaged under the circumstances described here;
- I/We have told Island Heritage Insurance everything relevant to this claim.

I understand that if I/We fail to provide accurate information, all benefits will be forfeited and cover cancelled immediately.

I undertake to render all possible assistance to Island Heritage Insurance in connection with this claim.

Insured's Signature: _____ Date (DD/MMM/YYYY): _____

Driver's Signature: _____ Date (DD/MMM/YYYY): _____

Island Heritage Insurance Company Ltd. is licensed and regulated to carry on insurance business in the Cayman Islands and all other territories where it does business.