THE MARITIME FINANCIAL GROUP

Head Office: #29 Tenth Avenue, Barataria

THIRD PARTY LOSS REPORT FORM

NAME OF OWNER/CLAIMANT:		**PHONE NO:**
ADDRESS:		**CELL NO:**
PROFESSION: OCCUPATION:		
NAME OF INSURANCE COMPANY:		
TYPE OF COVERAGE:		**POLICY NO:**
ARE YOU V.A.T. REGISTERED? :	**YES ( )**	**NO ( )**

DRIVER

NAME OF DRIVER:		**VEHICLE NO:**
ADDRESS:		**CELL NO:**
PROFESSION/OCCUPATION:		
DATE OF BIRTH:		**PERMIT NO:**
DATE OF ISSUE:		**EXPIRY DATE:**
DOES DRIVER OWN A VEHICLE:	**YES ( )**	**NO ( )**
NAME OF INSURANCE COMPANY:		**POLICY NO:**

MARITIME'S INSURED

INSURED'S NAME: **VEHICLE NO:**

POLICY NO:	**INSURED'S PHONE NO:**
DRIVER'S NAME :	**DRIVER'S PHONE NO:**
DRIVER'S ADDRESS:	

DETAILS OF ACCIDENT/LOSS

DATE OF ACCIDENT/LOSS:	**LOCATION:**
NAME OF OFFICER/NUMBER:	**TIME:**
ADDRESS OF POLICE STATION:	**REPORTED ON:**
DESCRIPTION/STATEMENT	

SKETCH

SHOW DIRECTION & POSITION OF AUTOMOBILES INVOVLED, DESIGNATING CLEARLY POINT OF CONTACT.

WITNESSES (IMPORTANT)

NAME	ADDRESS	TELEPHONE NO.

INJURY TO PERSONS

NAME	AGE	ADDRESS & CONTACT #	OCCUPATION
1)			
2)			
3)			

NATURE OF INJURIES	AMBULANCE NEEDED	HEALTH FACILITY
1)		
2)		
3)		

I/WE DECLARE THAT THE ABOVE PARTICULARS ARE TRUE & CORRECT TO THE BEST OF MY /OUR KNOWLEDGE & BELIEF.

_____ _____

SIGNATURE OF DRIVER **DATE**

_____ _____

SIGNATURE OF CLAIMANT / OWNER **DATE**