

**VIZION INSURANCE COMPANY, LTD.**

P.O. Box 503732 Saipan, MP 96950

VIZION INSURANCE Tel. No.: (670) 233-7251

AUTOMOBILE CLAIM FORM (INSURED)

Please submit the duly completed Claim Form with the documents required to expedite claim processing.
 The furnishing and/or acceptance of this form shall not be regarded as a waiver by the Company of its rights and the Company makes no admission of liability on the part of the Company.

GENERAL INFORMATION	
Name of Insured	
Policy No.	Claim No.
Mailing Address	Contact No.
Occupation	Employer
Driver's License No.	Driving Experience
Expiration Date	Age

DETAILS OF THE INSURED VEHICLE INVOLVED IN THE ACCIDENT	
Name of Driver	Age
Mailing Address	Contact No.
Driver's License No.	Expiration Date
Vehicle (Year, Make/Model, Color, License Plate No.)	
Location of the insured vehicle for inspection	Purpose of use of the vehicle at the time of the accident

DETAILS OF THE ACCIDENT	
Date/Time of Accident	Location of Accident
Direction you were traveling	Estimated speed of vehicle at the time of accident
Condition of road	Exact point of your vehicle with other vehicle/person
Description of Accident	
Please draw a rough sketch of the road indicating the position of the vehicle or person at the time of the accident	

Particulars of damage to insured vehicle	
List number of people in your vehicle at the time of the accident	Were there any injuries? YES or NO
List names and mailing address of persons injured as a result of this accident	

THIRD PARTY PROPERTY DAMAGE	
Description of Property	Owner of the Property
Address	Contact No.
Details of damage	

THIRD PARTY BODILY INJURY	
Name	Age
Address	Contact No.
Details of injuries sustained	

WITNESSES	
Names	Address and Contact No.

DECLARATION	
I/We hereby declare that the foregoing particulars to be true in every respect, and that I/we have no other policy of insurance indemnifying me/us in respect of this accident, and I/we undertake to assist Vizion Insurance Company within my/our power in dealing with the matter.	
_____	_____
Signature of Insured	Signature of Driver
Name :	Name :
Date :	Date :