ATLANTICTRUST
insurance brokers GmbH

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Agency Code: Policy No.: Claim No.:

Third party damage O Comprehensive O Collision or upset O

Claim Report: Please answer all questions carefully and truthfully.

Insured

Name of the Insured:__________ Rank:__________

Social Sec.No.__________ Tel.No.priv.__________ Duty:__________

Address(unit):__________ APO(loc.)__________

Address(priv):__________

e-mail address duty: __________ e-mail address private: __________

Date of birth:__________ DEROS:__________

Married and living with spouse in Germany? Yes O No O

Your vehicle

Motorcycle O Passenger car O Van O Trailer O

License Plate No. Chassis No. year of manufacture

Mileage Model Number of seats

How old are the tires of the car?
________km/miles until accident

Did your vehicle show any defects before the accident?(tires,breaks, steering etc.)

Lienholder

Is your vehicle financed? No O Yes O By whom?

Time and place of accident/ incident:

Date of accident/incident:__________ Hour:__________

Place of accident/incident:__________

Town/Highway to:__________

Driver of insured´s vehicle

Name and address of the driver:__________

Social Sec.No.:__________ Tel.No.:__________

Date of birth:__________ DEROS: __________

Did he own a valid driver's license?__________ Number:__________

Issued by:__________ Expiration date:__________

If driver other than insured,was he authorized?__________ If yes, by whom?__________

Did the driver consume alcohol before accident?__________

If so, during which period of time, what kind and quantities?__________

Was a blood test made?__________ If yes, Result:__________

Witnesses and Police

Names and addresses of passengers in your car:__________

Names and addresses of other witnesses:__________

Was the accident/incident investigated by the police? Yes O No O

German Police__________(agency, town)

Military Police__________(agency, town)

Was anybody fined at the scene of the accident? Yes O No O If yes, who ?

Description of accident/ incident (your vehicle No. 1)

____
____
____
____
____
____
____
____
____

Please draw diagram (showing positions of vehicles and persons involved, their approximate distance, and the direction in which they were moving.)

Circum-stances of accident

Speed of your vehicle at the time of the accident:

____________________mph

Weather conditions:

O clear O rain O fog O snow

Lighting: O daylight O dusk O dark

Speed of the other vehicle involved:

____________________mph

Road conditions:

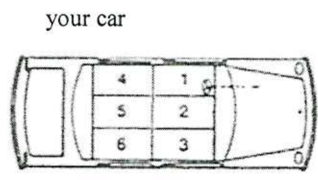
O black top O concrete O cobbled

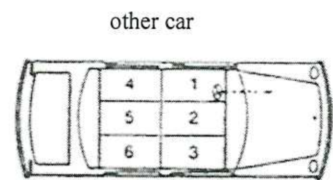
Condition of pavement:

O dry O slippery O icy O wet

Damage

your car **Please mark damage** other car





Extent of damage (for stolen parts state purchasing date, price and send original purchase bills):

____
____
____

Where can your car be inspected?

____
____

Estimated repair costs: ______________€

Name(s) and address(es) of owner(s) of other car(s) involved:

____
____
____

Kind of property (vehicles, fence, wall, guardrail) :

____
____
____

Please provide a written estimate and pictures in case of a comprehensive or collision claim !

Please complete only in case of theft

Was the vehicle itself stolen? O Yes O No

How was the vehicle secured against theft?

O windows closed O steering lock blocked O chain and lock

O doors locked O ignition key withdrawn O or otherwise:

Were the stolen parts locked up (inside) or were they fastened to the car?

O Yes,how?____________________________________ O No

Who parked the vehicle before the theft?______________________

Where?______________ Day:______________ Time:____________

Persons injured

Name	**address**	**age**	Were seat belts used? yes	No	Indicate the seat (No. see above) Occupant of insured car	Occupant of other car	Pedestrian or bicyclist
			O	O			
			O	O			
			O	O			

Nature and extent of injuries:____________________________________

If medical treatment was necessary, give name and place of hospital, doctor or dispensary:______________

____

These statements are true and made to the best of my knowledge. I know I shall lose my insurance coverage if these statements are not true and complete even if they do not cause any disadvantage to the insurer.

______________ Place and date

______________ Signature of insured

______________ Signature of driver