LFT - ACCIDENT CLAIM FORM

DATE OF ACCIDENT : ______________________ TIME: ______________________

LOCATION: ____

DRIVER 1:

NAME: ____

ADDRESS: ____

DOB: ______________________

LICENCE NO: ______________________

REGO NO: ______________________ VEHICLE OWNER: ______________________

VEHICLE MAKE MODEL: ______________________

DRIVER 2 /OTHER PARTY / COMPANY

NAME: ____

ADDRESS: ____

LICENCE NO: ____

REGO: ______________________

PHONE: ______________________ EMAIL: ______________________

BRIEF DESCRIPTION OF ACCIDENT: ____

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BRIEF DESCRIPTION OF DAMAGE TO DRIVER 1'S VEHICLE: ______________________

BRIEF DESCRIPTION OF DAMAGE TO DRIVER 2'S VEHICLE OR PROPERTY

Where there any witnesses to the incident. Please give details?

DRIVER 1

SIGNATURE:

Please complete and return this form to LFraumano Transport within 24 hours of any incident involving another party, no matter minor you may believe the incident to be .

Email: admin@lftransport.com.au