



MOTOR VEHICLE PROPOSAL

AGENCY NO:
CLIENT NO:

INSURED'S FULL NAME	DATE/S OF BIRTH.....	OCCUPATION/S
FATHER'S NAME	
DRIVER'S LICENCE NO:	
POSTAL ADDRESS:		TELEPHONE : WORK: HOME: E-MAIL:
ADDRESS WHERE VEHICLE IS USUALLY HOUSED		
NAME OF MORTGAGEE		
PERIOD OF COVER:	FROM: TO:	

VEHICLE DETAILS:

YEAR MODEL	MAKE & MODEL OF VEHICLE	MANUAL OR AUTO	ENGINE NO.	CHASSIS NO.
ENGINE SIZE	BODY TYPE (SEDAN, COUPE, UTE, VAN)	REGO. NO.	SUM INSURED MARKET VALUE INC. VAT	

WHAT IS THE PURPOSE OF USE? (PLEASE TICK) PRIVATE BUSINESS; TYPE OF BUSINESS

WHO IS THE OWNER OF THE VEHICLE?

UNDER WHOSE NAME IS THE VEHICLE REGISTERED?

WHERE AND WHEN THE VEHICLE WAS FIRST REGISTERED?

DO YOU HAVE ANY ACCESSORY OR SET OF ACCESSORIES THAT WERE NOT STANDARD WITH THE VEHICLE WHEN NEW VALUED OVER \$1,000 (MAG WHEELS, STEREO ETC)?

IS THERE ANY UNREPAIRED DAMAGE ON THE VEHICLE? YES NO

IF YES PLEASE SUPPLY FULL PARTICULARS IN EACH CASE:

ALL DRIVERS PLEASE STATE FULL NAME & TITLE (MR. MRS. MISS. MS.)	DATE OF BIRTH	YEARS LICENSED	CLASS OF LICENCE	% OF USE

DURING THE LAST 10 YEARS HAVE YOU OR ANY PERSON WHO MAY DRIVE THE VEHICLE, EVER HAD A DRIVING LICENCE ENDORSED SUSPENDED OR CANCELLED, BEEN CONVICTED OF ANY DRIVING OFFENCE OR ISSUED WITH AN OFFENCE NOTICE?
IF YES PLEASE DETAIL BELOW.

DRIVERS NAME	CONVICTION DETAILS	DATE	PENALTY

NUMBER OF CONSECUTIVE YEARS THE REGULAR DRIVER HAS HELD COMPREHENSIVE MOTOR INSURANCE IMMEDIATELY PRIOR TO THIS APPLICATION?

DURING THE LAST 10 YEARS HAVE YOU OR ANY PERSON WHO MAY BE DRIVING THE VEHICLE HAD A MOTOR VEHICLE ACCIDENT OR CLAIM? IF YES PLEASE DATAIL.

DETAILS	INSURANCE CO.	AMOUNT	DRIVERS NAME	BONUS LOST?

PREVIOUS INSURANCE COMPANY DETAILS:

NAME ADDRESS

CUSTOMER REF. EXPIRY DATE VEHICLE DETAILS

NOTE: EVIDENCE OF CLAIMS EXPERIENCE FROM PREVIOUS INSURER SHOULD BE ATTACHED TO THIS PROPOSAL

COVER OPTIONS

Please indicate with a tick which option you require

MOTOR CARE

Third Party fire & Theft

Rental Vehicle

Windscreen/Window Glass

BASIC THRIFTI PROTECTION

Passenger risk extension

Please tick which Voluntary excess you require: \$500 \$750 \$1,000 \$2,000

OFFICIAL USE ONLY

ENDORSEMENTS

REPLACING

COVER NOTE

PREMIUM

ANNUAL

QUARTERLY

MONTHLY

CO PREMIUM	OPT. BENEFITS	STAMP DUTY	ADMIN FEE	ANNUAL PREMIUM	INST. AMOUNT

Declaration

I/We confirm that I/We have read and understood all the questions and answers on this proposal and that where it has been completed on my/our behalf by another person such as an agent/or an employee of FijiCare Insurance Ltd, I/We have read and confirmed all the information provided is correct.

Signature of Insured

Date