E

Notice of Claim

PURSUANT TO TITLE 59

Forward to:

1. Claimant:

Last First Middle Area Code/Telephone No.

Street Address Additional Address

Date of Birth Soc. Security No. City State Zip

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please complete this section.

Name Street Address

Additional Address City State Zip

Area Code/Telephone No. Relationship to Claimant

3. Accident:

A. The occurrence or accident which gave rise to this claim:

Date Time

B. Describe the location or place of the accident or occurrence:

Municipality Exact Location of the Occurrence

C. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

D. State the name and address of the municipality or agency that you claim caused your damage.

_____

_____

E. State the names of municipal board employees whom you claim were at fault, including any information that will assist in identifying them.

_____

_____

_____

F. State in detail each and every negligent or wrongful act of the municipality and municiapl employees which caused your damage.

_____

_____

_____

_____

_____

G. State the name and address of all witnesses to the accident or occurrence.

_____

_____

_____

H. If vehicle accident, state the names, addresses, age, and relationship to insured of all passengers in your vehicle.

_____

_____

_____

I. State the names of all police officers and police departments who investigated the accident.

_____

_____

_____

4. Claim for damages

A. Claim for damages (Check appropriate box)

_____Bodily Injury _____Property Damage _____Other

If other, explain:_____

_____

B. i. If you claim bodily injury - describe your injuries resulting from this accident or occurrence.

_____

_____

_____

ii. Do you claim permanent disability resulting from this injury?

☐ Yes ☐ No

If yes, describe the injuries believed to be permanent.

_____

_____

_____

iii. For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, please list:

_____
Name of Hospital, Doctor, or other Facility

_____ _____
Address City State Zip

_____ _____
Date of Treatment Amount of Charges

_____
Amount Paid if Payable by other sources, i.e., insurance

iv. If you claim loss of wages or income as a result of the injury, state:

_____ _____
Name of Employer Your Occupation

_____ _____
Address City State Zip

_____ _____
Date Employed at this Job Rate of Pay

_____ _____
Dates of Absences from Work Total Lost Wages to Date

_____
If still out of work,
expected date of return

NOTE: If your claimed loss of income arises from self-employment or other wage, attach a calculation showing the basis of your calculation of lost income.

v. Set forth any and all other losses or damages claimed by you.

_____

_____

_____

C. If you claim property damage:

i. Describe the property damaged. If vehicle, include make, model, year, color, vehicle identification number, license plate number, state, and parts of vehicle damaged.

_____

_____

_____

ii. The present location and time when the property can be inspected.

_____

_____

iii. Date property acquired_____

iv. Cost of the property_____

v. Value of property at time of accident_____

vi. Description of damage

_____

_____

_____

vii. Has the damage been repaired?

☐ Yes ☐ No

If yes, by whom, and cost of repairs.

_____

_____

viii. Attach each estimate of repair costs to this form.

ix. Set forth in detail the loss claimed by you for property damage.

_____

_____

_____

D. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

_____

_____

_____

_____

5. The amount of the claim_____

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice?

☐ Yes ☐ No

If yes, set forth the names and address of all persons and the insurance companies against whom you have made such claims.

_____

_____

_____

7. Are any of the losses or expenses claimed herein covered by any policy of insurance?

☐ Yes ☐ No

For each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable.

_____

_____

_____

8. Have you received or agreed to receive any money from anyone for damages claimed herein?

☐ Yes ☐ No

If yes, set forth the details of such agreement.

_____

_____

_____

_____

_____

The following items must be submitted with this notice:

1. Copies of itemized bills for each medical expense and other losses and expenses claimed.

2. Full copies of all appraisals and estimates of property damage claimed by you.

3. Copies of all written reports of all expert witnesses and treating physicians.

4. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claim lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bill, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

Date _____ Claimant or person filing on behalf of claimant.

_____
Print Name as Signed Above

***Notice of Claim must be filed with the Public Entity within 90 days after the incident giving rise to the claim. Failure to complete the Notice of Claim form in a timely manner may bar recovery.

Authorization for Medical Reports and Records

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to claims servicing organizations or its representatives any and all records, reports and other information concerning the treatment of the claimant named herein. Photostatic copies of the Authorization carry the same Authority as the original.

Date _____ Signature

(This must be signed by the claimant or parents of the claimants who are minors.)

_____
Print Name as Signed Above

Authorization for Information on Employment

TO WHOM IT MAY CONCERN:

I hereby authorize _____ to release any and all information concerning my employment, past or present, including rate of pay, duties performed, dates of absences and reasons therefor. Photostatic copies of this Authorization carry the same Authority as the original.

Date _____ Signature

_____
Print Name as Signed Above

\SELF\NOTCLM.JIF