

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 municipal 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

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

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