

Notice of Claim

Claimant:

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Last First Middle

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Street Address

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City State Zip

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Area Code/ Telephone Number

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Additional Address

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Date of Birth Social Security Number

If Notices and correspondence in connection with this claim are to be sent to a person other than the claimant, please complete item #2

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Last First Middle

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Street Address

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City State Zip

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Area Code/ Telephone Number

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Additional Address

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Relationship to the Claimant

- a) The occurrence or accident which gave rise to this claim

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Date

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Time

- b) Describe the location of the accident or occurrence:

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Municipality

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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.

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

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- e) State the names of the municipality's employees whom you claim were at fault, including information that will assist in identifying them.

f) State in detail each and every negligent or wrongful act of municipality and municipality's 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 name, 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.

a) Claim for Damages (check appropriate box)

Bodily Injury Property Damage Other (explain)

b) 1) If you claim bodily injury, describe the injuries resulting from the accident.

2) Do you claim permanent disability from this injury? Yes No

If yes, describe the injuries believed to be permanent.

3) For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic service, state:

Name of Hospital, Doctor or other Facility	Address	Dates of Treatment/ Service	Amount of Charges to Date	Amt Paid or Payable by other sources (i.e. insurance)

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

Name of Employer	Address
Your Occupation	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 than wage attach a calculation showing the basis of your calculation of lost income.

5) Set forth any and all losses or damages claimed by.

c) If you claim property damage:

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

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

c. Date property acquired:

d. Cost of the property:

e. Value of the property at the time of accident:

f. Description of the damage:

g. Has the damage been repaired: Yes No

h. If yes, by whom, and cost of repairs.

i. Attach each estimate of repair cost to this form.

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

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

- l. The amount of the claim.

- m. Have you made a claim against anyone else for any losses or expenses claimed in this notice.

Yes No

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

- o. Have you ever received or agreed to receive any money from anyone for damages claimed herein:

Yes No

- p. If so, 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 loss of wages. If self-employed, a statement showing the calculations of your claim lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, 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 the law.

Dated:

Claimant or person filing on behalf of claimant

Print name as signed above

Authorization for Medical Reports & Records

To whom it may concern:

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to 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.

Dated:

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.

Dated:

Signature

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

Print name as signed above