NOTICE OF CLAIM FORM

Forward to:

1. Claimant:

Last First Middle

Area Code/Telephone Number

Street Address

Additional Address

Date of Birth

Social Security Number

City State/Zip Code

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 Code

Area Code/Telephone Number

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:

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(s) that you claim caused your damage.

E. State the names of the municipal 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 the municipality's employees which caused your damage.

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

H. If a vehicle accident, state the names, age, address, phone number, and relationship to you, 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?

_____

_____

_____

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 Code

_____ _____
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 Code

_____ _____
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 wages, 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 claimed 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 law.

_____ _____

Date Claimant or person filing on behalf of claimant.

_____

Print name as signed above.