NOTICE OF CLAIM

Forward To: Office of the City Clerk
44 City Hall Plaza
East Orange, NJ 07019

1. Claimant:

Last Middle First — (Area Code) Telephone Number

Street Address — Mailing Address, if different

City State Zip Code — Date of Birth / Social Security No.

If Notice and correspondence in connection with this claim are to be sent to a person other than claimant, complete No. 2.

2. Name — (Area Code) Telephone Number

Mailing Address — City State ZIP

a. Relationship to claimant: Spouse [ ] or ____________ Explain Relationship

3. a. The occurrence or accident that gave rise to this claim:

Date — Time

b. The municipality and location or place of the accident or occurrence:

Municipality — Exact Location/Place of Incident

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 you damage:

____

____

____

State the names of Municipality's employees whom you claim were at fault, including any information that will assist in identifying and locating them:

____

____

____

e. State in detail each and every negligent or wrongful act of the Municipality and municipal employees who caused your damages:

____

____

____

____

f. State the names and addresses of all witnesses to the accident or occurrence:

____

____

____

g. If a vehicle accident, state the names, addresses, ages and relationships to insured of all passengers in your vehicle:

____

____

____

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

____

____

____

4. a. Claim for damages (check correct space): [ ] Bodily Injury [ ] Property Damage

[ ] Other (Explain) ______________________________

b. If you claim Bodily Injury:

(1) Describe your injuries resulting from this accident or occurrence: ________

____

(2) Do you claim permanent disability resulting 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	Address	Treatment Dates	Amt. of Charges to Date	Amt. Paid or Payable other source (insurance)

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

____
Name of Employer

____
Address of Employer

____
Your Occupation

____
Date You Were Employed at this Job

____
Rate of Pay

____
Dates of Absence from Work

____
Total Lost Wages to Date

____
Expected Return Date (if applicable)

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

(5) Set forth any and all other losses or damages claimed by you:

____

____

____

c. If you claim Property Damage:

(1) Describe the property damaged (if vehicle, include make, model, year, color, vehicle identification number, license plate number and state, and parts of vehicle damaged):

____

____

____

(2) The present location and time when the property may be inspected:

____

(3) Date property acquired: ______________________________

(4) Cost of the property: $______________________________

(5) Value of the property at time of accident: $______________________________

(6) Description of damage: ______________________________

____

(7) Has damage been repaired? ______ If so, by whom, when and cost of repairs:

____

(8) Attach each estimate of repair costs to this form.

(9) 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 of Claim? [ ] Yes [ ] No

   If Yes, set forth the names and addresses of all persons and 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

   If Yes, for each such policy, state the names and addresses 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: ______________________________

   ____

   ____

9. The following items must be submitted with the Notice of Claim:

   a. Copies of itemized bills for each medical expense and other losses and expenses claimed.
   b. Full copies of all appraisals and estimates of property damaged claimed by you.
   c. Copies of all written reports of all expert witnesses and treating physicians.
   d. A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.
   e. Signed Medical and/or Lost Wage Information authorization release (see Page 6).

I hereby certify that the foregoing statements made by me are true, and 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 provided by law.

Dated: ______________________ ______________________________
Claimant (or person filing claim on claimant's behalf)

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

______________________________ ______________________
Signature Date

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU.

______________________________ ______________________
Signature Date

Social Security No. ____________________