Instructions For Filing An Insurance Claim Against A Municipality or Public Entity

In order to file an insurance claim against a municipality, you must complete the attached Notice of Claim Form.

You should notify your insurance carrier first about your claim. Under State Law (NJSA 59:9:2e) your insurance carrier pays first. The municipality/public entity, if legally liable for this loss, will pay only the uninsured portion of your claim.

It is necessary to prove that you do not have personal coverage for this incident by submitting a copy of your policy coverages or a declination letter from your insurance carrier.

A public entity is legally allowed up to six (6) months to investigate and adjust your claim or prepare a defense.

Please complete the attached Notice of Claim Form within 90 days of your loss and submit it to the Risk Manager at 344 Broadway, Long Branch, New Jersey, 07740.

NOTICE OF CLAIM

Claimant

_____	_____
Name	Date of Birth
_____	_____
Address	Mailing Address
_____	_____
City, State & Zip Code	Social Security #
_____	
Phone Number	

If notices and correspondences in connection with this claim are to be sent to a person other than the claimant, complete below.

_____

Name and Mailing Address

_____

Relationship to the claimant

The occurrence which gave rise to this accident:

_____	_____
Date	Time

Describe the location or place of the accident or occurrence:

Describe your accident facts. If you need further space, please utilize the reverse side of this form:

State the name and address of the Municipality or Agency that you claim caused your damage:

State the names of Municipal employees whom you claim were at fault, including the department they are employed with.

State in detail each and every negligent or wrongful act of the Municipality and Municipal employees which caused your damage and injury.

State the name(s) and address of all witnesses to this accident:

_____

_____

State the names of all police officers and municipal department who investigated the accident:

_____

_____

Please indicate if this is a claim for property damage ( ) bodily injury ( ) other ( ) explain:

_____

If you claim bodily injury:

Describe your injuries resulting from this accident or occurrence:

_____

_____

_____

Do you claim permanent disability resulting from this injury? _____

If Yes, describe the injuries believed to be permanent:

_____

_____

State the name, address, date(s) of treatment, type of treatment and amount of charges given by any hospital, doctor or other practitioner rendering medical care or diagnostic service:

State the amount paid or payable by other collateral sources such as health insurance and attach all medical reports and bills incurred to date:

If you claim loss of income as a result of the injury, state the name and address of the employer, your occupation, rate of pay, dates of absence from work and what amount was paid by your employer. Attach loss income verification from your employer.

If your loss of income arises from self-employment, attach a calculation indicating the basis of your loss of income along with your last complete year of income tax records.

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

_____

_____

_____

_____

If you claim property damage:

Describe the property damaged:

_____

_____

_____

The present location and time when the property can be inspected:

_____

Date property acquired: _____

Cost of Property: _____

Value of Property: _____

Description of Damage: _____

Has the damage been repaired? _____ If so, by whom, when and the cost of replacement (attach receipts)

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

Attach all available receipts which verify the cost of items claimed.

The total amount of your claim: _____

Have you made claim against anyone else for any of the losses or expense claimed in this notice?

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such a claim

State the amount paid by this source: _____

Copies of all appraisals and estimates of property damage should be attached with this notice.

I hereby certify that the foregoing statements made by me are true and that I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment provided by law.

Date: _____ Signed By: _____

AUTHORIZATION

I/We, the undersigned, authorize any and all doctors, hospitals or other medical service providers to release all records, reports and other pertinent information concerning the treatment of the claimant stated herein. I /We further authorize the release of all employment information for any claim made for a loss of income.

This authorization is valid for the duration of this claim and photocopy of this form is as valid as the original.

Full Name: _____

Social Security Number: _____