Notice of Tort Claim

General Information

Name of City, County, or Public Trust whom you allege is at fault.

1. Claimant Information

(If claimaint is an entity like a corporation, state your name and on whose behalf you are completing this form)

List any additional claimants in Section 9

Full Name (First, Middle. Last)		
Address (Number and Street)		Apt., Suite, Unit
City	State	ZIP code
Phone	Email	

If you have a Medicare number, provide the following information:

Identification Number (HICN, MBI, or last 5 of SSN)	Gender	M ☐	F ☐	Date of Birth

2. Description of Property Damage

Describe when, where, and how your property was damaged.

Date	Time	Location(be as specific as possible)

3. Claims For Damage to Property

Description of Damages

Amount of compensation requested	$	

How did you determine the amount of compensation requested?

Describe the damage to property

Required attachments for property damge claims

- ☐ Attach at least two (2) estimates or quotes for the repair costs of the damage.
- ☐ Attach photographs of the claimed damage.
- ☐ Attach proof of ownership for the damaged property, (e.g. title or registration to vehicle, etc.)

Required attachments for claims of total loss of property

- ☐ Attach a list of each item for which you claim total loss
- ☐ For each item listed, identify its fair market value at the time of loss
- ☐ Attach before and after photographs (if available).
- ☐ Attach documentation that supports each loss claimed.

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4. Description of Other Loss

Describe when, where, and how you experienced other loss not described in section 2-3.

Date	Time	Location

5. Claims For Other Loss

Desciption of Damages

Amount of compensation requested	$	
Describe the other loss being claimed.		

Required attachments for all claims for other loss

☐ Attach documentation that supports your claimed loss.

Required supporting documentation if your other loss is a personal injury claim

☐ Attach a copy of your medical bills for which you seek compensation.

☐ You **MUST** provide the contact information for **every** healthcare provider from whom you sought treatment or received medical care, treatment, or medicine related to your personal injury claim by completing Section 10 (page 5).

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Insurance Information

6. Property Insurance Information

Was your property insured for the loss claimed?			Yes ☐	No ☐
If you answered "yes", provide the insurance company's contact information below.				
Name of Insurer			Phone	
Address (Number and Street)		Suite, Unit		
City		State		ZIP code
Was a claim filed with your property insurance?			Yes ☐	No ☐
Claim Amount	$	Amount Received	$	

7. Other Loss Insurance Information

Is there insurance that covers the other loss claimed?			Yes ☐	No ☐
If you answered "yes", provide the insurance company's contact information below.				
Name of Insurer			Phone	
Address (Number and Street)		Suite, Unit		
City		State		ZIP code
Was a claim filed with this insurance company?			Yes ☐	No ☐
Claim Amount	$	Amount Received	$	

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Additional Information

Complete Section 8 - 9 if there are any known witnesses to the incident or if there are additional claimants.

8. Witness Contact Information

Witness 1

Full Name (First, Middle, Last)				
Address (Number and Street)	Apt. / Suite	City	State	ZIP code
Phone	Email			

Witness 2

Full Name (First, Middle, Last)				
Address (Number and Street)	Apt. / Suite	City	State	ZIP code
Phone	Email			

9. Additional Claimants

Additional Claimant 1

Full Name (First, Middle. Last)		
Address (Number and Street)	Apt., Suite, Unit	Email
City	State	ZIP code
Phone	***Business Filers Only*** EIN	

If Additional Claimant 1 has a Medicare number, provide the following information:

Identification Number (HICN, MBI, or last 5 of SSN)	Gender	M ☐	F ☐	Date of Birth

Additional Claimant 2

Full Name (First, Middle. Last)		
Address (Number and Street)	Apt., Suite, Unit	Email
City	State	ZIP code
Phone	***Business Filers Only*** EIN	

If Additional Claimant 2 has a Medicare number, provide the following information:

Identification Number (HICN, MBI, or last 5 of SSN)	Gender	M ☐	F ☐	Date of Birth

List of Healthcare Providers

10.

Provide the contact information for **every** healthcare provider who provided treatment relating to your claims. Healthcare providers include but are not limited to: emergency medical services providers, health care clinics, hospitals, pharmacies, physicians, psychiatrists, therapists and all other medical service, medical equipment, and medicine providers

Healthcare Provider 1	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 2	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 3	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 4	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 5	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 6	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	
Healthcare Provider 7	Name			Phone		
	Address (Number and Street)	Apt. / Suite	City	State	ZIP code	

We may contact you to request a release of medical information related to your claim, and if necessary we will have you complete medical authorizations for all relevant healthcare providers.