File#: _____

Clmt: _____

NOTICE OF CLAIM

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF ACCIDENT/OCCURRENCE OR YOU MAY FORFEIT YOUR RIGHTS PURSUANT TO N.J.S.A. 59:1 ET SEQ.

FORWARD TO: Township of Berkeley Heights
29 Park Avenue
Berkeley Heights NJ 07922

1) CLAIMANT:

_____ _____
Last First Middle (Area Code) Phone#

_____ _____
Street Address Additional Address

_____ _____
City, State Zip Code D/O/B SS#

2) IF NOTICE AND CORRESPONCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, PLEASE COMPLETE ITEM #2:

_____ _____
Last First Middle (Area Code) Phone#

_____ _____
Street Address Additional Address

_____ _____
City State Zip Code D/O/B SS#

3)

A) THE OCCURANCE OR ACCIDENT WHICH GAVE RISE TO THIS CLAIM:

_____ _____
Date Time

B) DESCRIBE THE LOCATION OR PLACE OF THE ACCIDENT OR OCCURRENCE:

_____ _____
Municipality Exact Location

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 ADDRESS OF THE MUNICIPALITY OR AGENCY THAT YOU CLAIM CAUSED YOUR DAMAGE:

E) STATE THE NAMES OF MUNICIPALITY'S 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 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 NAMES, ADDRESS, 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:

4)

A) CLAIM FOR DAMAGES (check appropriate box):

□ BODILY INJURY □PROPERTY DAMAGE □OTHER EXPLAIN

B)

1) IF YOU CLAIM INJURY, 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 & ADDRESS OF HOSPITAL, DOCTOR, OR OTHER FACILITY	DATES OF TREATMENT	AMOUNT OF CHARGED TO DATE	AMOUNT PAIDOR PAYABLE BY OTHER INSURANCE
A)			
B)			
C)			
D)			

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

NOTE: IF YOUR CLAIMED LOSS OF INCOME ARISES FROM SELF-EMPLOYMENT OR OTHER THAN WAGE, ATTACH A CALCULATION ON THE BASIS OF YOUR CALCULATION OF LOSS 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, STATE, AND PARTS OF VEHICLE DAMAGED:

_____

_____

_____

_____

2) THE PRESENT LOCATION AND TIME THE PROPERTY CAN BE INSPECTED:

_____

_____

_____

3) DATE PROPERTY WAS ACQUIRED:

4) COST OF PROPERTY:

5) VALUE OF PROPERTY AT THE TIME OF ACCIDENT:

6) DESCRIPTION OF DAMAGE:

7) HAS THE DAMAGE BEEN REPAIRED?
□YES □NO
IF YES, BY WHOM, AND COST OF REPAIRS:

8) ATTACH EACH ESTIMATE OF REPAIR COST TO THIS FORM.

9) SET FORTH IN DETAIL THE LOSS CLAIM 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 CALCULATIONS:

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 ADDRESSES OF ALL PERSONS AND THE INSURANCE COMPANIES AGAINST WHO 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 AGREE TO RECEIVE ANY MONEY FROM ANYONE FOR DAMAGES CLAIMED HEREIN?

□YES □NO

IF YES, SET FORTH THE DETAILS OF SUCH AGREEMENT:

_____

_____

_____

_____

_____

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Clmt: _____

9) 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 READING PHYSICIANS.
4) A LETTER FROM YOUR EMPLOYER VERIFYING YOUR LOST WAGES. IF SELF EMPLOYED A STATEMENT SHOWING CALCULATIONS OF YOUR 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 ONE 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.

DATED: _____

_____
Claimant or person filing on behalf of claimant

_____
Print name as signed above

File#: _____

Clmt: _____

AUTHORIZATION FOR MEDICAL REPORTS & RECORDS

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE TOWNSHIP OF BERKELEY HEIGHTS , RISK MANAGEMENT DIVISION OR CLAIMS DEPARTMENT OR ITS REPRESENTATIVES ALL INFORMATION, RECORDS, X-RAYS, REPORTS, OR COPIES RELATING TO THE TREATMENT PROVIDED TO ME WHILE A PATIENT. THIS INCLUDES COPYING, INSPECTING, OR EXAMINING SAME.

A PHOTOCOPY OF THIS DOCUMENT WILL BE ACCEPTABLE AS AN ORIGINAL.

DATED: _____ _____

Signature

THIS MUST BE SIGNED BY THE CLAIMANT OR PARENTS OF THE CLAIMANT WHO ARE MINORS.

_____

Print name as signed above

File#: _____

Clmt: _____

AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE TOWNSHIP BERKELEY HEIGHTS, RISK MANAGEMENT DIVISION OR CLAIMS DEPARTMENT OR ITS REPRESENTATIVES ANY AND ALL MEDICAL INFORMATION CONCERNING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING RATE OF PAY, DUTIES TO BE PERFORMED, DATES OF ABSENCES AND REASONS THEREFORE.

A PHOTOCOPY OF THIS DOCUMENT WILL BE ACCEPTABLE AS AN ORIGINAL.

DATED: _____

_____
Signature

_____
Print name as signed above