NOTICE OF CLAIM

FORWARD TO: TOWNSHIP OF MILLSTONE
Attn: Municipal Clerk
470 Stagecoach Road
Millstone Township, NJ 08510

1) CLAIMANT:

Last First Middle

Area Code/Phone #

Street Address

Additional Address

City State Zip Code

D/O/B SS#

2) IF NOTICE AND CORRESPONDENCE 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 OCCURRENCE 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 AND 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 PRACTITIIONER RENDERING TREATMENT, EXAMINATION OR DIAGNOSTIC SERVICE, STATE:*

NAME & ADDRESS OF HOSPITAL, DOCTOR, OR OTHER FACILITY	DATES OF TREATMENT	AMOUNT OF CHARGE TO DATE	AMOUNT PAID OR 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 OR EXPENSES CLAIMED IN THIS NOTICE?*

☐ YES ☐ NO

IF YES, SET FORTH THE NAMES AND ADDRESSES 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:

_____

_____

_____

_____

_____

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 TREATING PHYSICIANS.

4. A LETTER FROM YOUR EMPLOYER VERIFYING YOUR LOST WAGES. IF SELF EMPLOYED, A STATEMENT SHOWING CALCULATIONS OF YOUR CLAIM 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.

DATED: _____

_____
Claimant or person filing on behalf of claimant

_____
Print name as signed above

AUTHORIZATION FOR MEDICAL REPORTS & RECORDS

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE ANY AND ALL DOCTORS, HOSPITALS OR OTHER MEDICAL SERVICE FACILITIES TO RELEASE TO MIDDLESEX COUNTY MUNICIPAL JOINT INSURANCE FUND CLAIMS DEPARTMENT OR ITS REPRESENTATIVES ANY AND ALL RECORDS, REPORTS AND OTHER INFORMATION CONCERNING THE TREATMENT OF THE CLAIMANT NAMED HEREIN. PHOTOSTATTED COPIES OF THE AUTHORIZATION CARRY THE SAME AUTHORITY OF ORIGINAL.

DATED:_____

_____
Signature

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

_____
Print name as signed above

AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE _____ TO RELEASE ANY AND ALL MEDICAL INFORMATION CONCERNING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING RATE OF PAY, DUTIES PERFORMED, DATES OF ABSENCES AND REASONS THEREFOR. PHOTOSTATTED COPIES OF THIS AUTHORIZATION CARRY THE SAME AUTHORITY AS THE ORIGINAL.

DATED:_____ _____

Signature

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

_____

Print name as signed above