CLAIM FOR DAMAGES AGAINST THE TOWN OF MORRISTOWN

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.

1. CLAIMANT INFORMATION

DATE OF ACCIDENT

AMOUNT OF CLAIM

LAST NAME

DATE OF BIRTH

STREET ADDRESS

MAILING ADDRESS

CITY, STATE, ZIP CODE

SOCIAL SECURITY NUMBER

MARITAL STATUS

NUMBER OF DEPENDENTS

HOME PHONE

WORK PHONE

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

NAME

MAILING ADDRESS

CITY, STATE, ZIP CODE

Relationship to Claimant:

Attorney at Law ( ) or _____
Relationship

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

a. _____ _____
Date Time

_____
Municipality Exact location of the occurrence

c. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please attach hereto.

_____

_____

_____

d. State the names of public employees and or public agencies whom you claim were at fault, including any information that will assist identifying and locating them.

_____

_____

_____

e. State the negligence or wrongful acts of the public agency or its employees which allegedly caused your damages.

_____

_____

f. State the name and address of all witnesses to the accident or occurrence.

_____

_____

_____

g. State the names of all Police Officers and Police Departments who investigated the accident.

_____

_____

4. a. Claim for damages (check appropriate block)

☐ Property damages

☐ Personal injury

☐ Other-explain in detail

b. If you claim personal 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:

I. Name of Hospital, Doctor or Facility	II. Address	III. Dates of Treatment or service	IV. Amount of charges to date

5. Are you covered by any health insurance policy? If so, please advise name and address of carrier, named insured and policy number.

List bills submitted to carrier:

6. 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 became employed at this job
Rate of pay	Dates absent from work
Total lost wages to date	If still out of work, expected date of return

If injury is associated with an auto accident, please provide name of auto insurance carrier and policy number.

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

7. Set forth any and all losses or damages claimed by you.

c. If you claim property damage:

1. Describe the property damaged.

2.Present location and time when the property may be inspected.

3. Date property acquired _____

4. Cost of property _____

5. Value of property at time of accident _____

6. Description of damage

_____

_____

7.Has the damage been repaired? ☐ Yes ☐ No 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.

_____

_____

8. State the total amount of damages (personal, property and other) you are claiming.

_____

9. 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 address of all persons and insurance companies against whom you have made such claims.

_____

_____

10. 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.

11. 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 lost wages. If self employed, a statement showing the calculation of your claimed 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 in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by law.

Claimant or person filing on behalf of claimant

Date

MEDICAL/EMPLOYMENT INFORMATION RELEASE AUTHORIZATION

To Whom It May Concern:

I hereby authorize any and all doctors, or other medical service facilities to release to

_____ or their representative any and all records, reports and other information concerning the treatment of the claimant named herein.

I also hereby authorize my employer to release all wage's, salary and related compensation information.

_____
Signature

_____
Date

(This must be signed by the claimant or the parents of claimants who are minors)

COMPLETED FORM MUST BE FORWARDED TO:

Town of Morristown
Margot Kaye, Town Clerk
P.O. Box 914
Morristown, NJ 07963-0914