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

1) CLAIMAINT INFORMATION

DATE OF ACCIDENT	$ AMOUNT OF CLAIM
LAST NAME, FIRST NAME, MIDDLE	DATE OF BIRTH
STREET ADDRESS	MAILING ADDRESS
CITY, STATE ZIP CODE	SOCIAL SECURITY NUMBER
MARITAL STATUS	NUMBER OF DEPENDENTS
PRIMARY PHONE	WORK PHONE

IF NOTICE AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN THE CLAIMANT, COMPLETE ITEM No. 2.

2) CLAIMAINT INFORMATION

NAME	MAILING ADDRESS
	CITY, STATE, ZIP CODE
RELATIONSHIP TO CLAIMANT ATTORNEY-AT-LAW OR	RELATIONSHIP

3) THE OCCURRENCE OR ACCIDENT WHICH HAS GIVEN RISE TO THIS CLAIM:

3A. DATE	TIME

B. DESCRIBE THE LOCATION OR PLACE OR THE OCCURRENCE:

MUNICIPALITY	EXACT LOCATION OF THE OCCURENCE

C. DESCRIBE HOW THE ACCIDENT OR OCCURRENCE HAPPENED. IF A DIAGRAM WILL ASSIT YOUR EXPLANATION, PLEASE ATTACH HERETO.

D. STATE THE NAMES OF THE 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 OCCURENCE.

G. STATE THE NAME AND ADDRESS OF ALL POLICE OFFICERS AND POLICE DEPARTMENTS WHO INVESTIGATED THE ACCIDENT.

H. DID LOSS OR INJURY OCCUR DURING THE COURSE AND SCOPE OF YOUR EMPLOYMENT?_____

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 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 TREATMENT,EXAMINATION, OR DIAGNOSTIC SERVICE, STATE:

I. NAME OF HOSPITAL DOCTOR OR OTHER TREATMENT FACILITY	II.ADDRESS	III DATES OF TREATMENT OR SERVICE	IV.AMOUNT OF CHARGES TO DATE

(4) 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.

(5) 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 OF ABSENCE FROM WORK
TOTAL LOST WAGES TO DATE	IF STILL OUT OF WORK, EXPECTED DATE TO RETURN

IF INJURY IS ASSOCIATED WITH AN AUTO ACCIDENT, PLEASE PROVIDE THE NAME OF THE AUTO INSURANCE CARRIER AND POLICY NUMBER.

NOTE: IF YOUR CLAIMED LOSS OF INCOME ARISES FROM SELF EMPLOYMENT OR OTHER THAN WAGES, ATTACH A CALCULATION SHOWING THE BASIS OF YOUR CALCULATION OF LOST INCOME.

(6) SET FORTH ANY AND ALL LOSSES OR DAMAGES CLAIMED BY YOU.

A. IF YOU ARE CLAIMING 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? _____ 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.

A. SET FORTH IN DETAIL ALL OTHER ITEMS OF LOSS OR DAMAGES CLAIMED BY YOU AND THE METHOD BY WHICH YOU MADE THE CALCULATION.

(10) STATE THE TOATAL AMOUNT OF DAMAGES (PERSONAL,PROPERTY AND OTHER) YOU ARE CLAIMING. _____

(11) HAVE YOU MADE A CLAIM AGAINST ANYONE ELSE FOR ANY OF THE LOSSES OR EXPENSES CLAIMED IN THIS NOTICE?

IF YES, SET FORTH THE NAMES AND ADDRESSES OF ALL PERSONS AND INSURANCES COMPANIES AGAINST WHOM YOU HAVE MADE SUCH CLAIMS.

(12) ARE ANY OF THE LOSSES OR EXPENSES CLAIMED HEREIN COVERED BY ANY POLICY OF INSURANCE? _____

FOR EACH SUCH POLICY, STATE THE NAME AND ADDRESS OF THE INSURANCE COMPANY, POLICY NUMBER AND BENEFITS PAID OR PAYABLE..

(13) HAVE YOU RECEIVED OR AGREED TO RECEIVE ANY MONEY FROM ANYONE FOR THE DAMAGES CLAIMED HEREIN _____IF SO, SET FORTH THE DETAILS OF SUCH AGREEMENT.

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE:

(1) COPIES OF ITEMIZED BILLS FOR EACH MEDICAL EXPENSES 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 CALCULATION OF YOUR CLAIMED LOST INCOME.

I HERE CERTIFY THAT THE FOREGOING STATEMENT MADE BY ME ARE TRUE. THAT THE ATTACHED STATEMENTS, BILLS, REPORTS AND DOCUMENTS ARE THE ONLY ONE 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:_____

TO WHOM IT MAY CONCERN:

I HEREBY AUTHORIZE ANY AND ALL DOCTORS, HOSPITALS, OR OTHER MEDICAL SERVICES FACILITIES TO RELEASE TO THE CITY OF UNION CITY, 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 WAGES, 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:

OFFICE OF THE MUNICIPAL CLERK
CITY OF UNION CITY
3715 PALISADE AVE
Union City, New Jersey 07087