

CITY OF LINDEN  
OFFICIAL CLAIM FORM

THIS CLAIM FORM MUST BE FILED WITHIN NINETY(90) DAYS OF ACCIDENT OR OCCURRENCE OR YOU MAY FORFEIT YOUR RIGHTS PURSUANT TO N.J.S.A. 59:8-1 et seq.

FORWARD TO: City Clerk's Office, City of Linden, City Hall  
301 N. Wood Avenue, Linden, N.J. 07036

1. Claimant:

Last Name			First	Middle	Date of Birth		
Street Address					Mailing address if other than address		
City		State	Zip Code		Social Security Number		

If notices and correspondence in connection with this claim are to be sent to a person other than claimant, complete Item #2.

2. \_\_\_\_\_

Name			Mailing Address		
		City	State	Zip Code	

Relationship to claimant: Spouse ( ) or \_\_\_\_\_  
Explain Relationship

3a. 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 of the occurrence
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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 Municipal Department, if any, that you claim caused your damage

\_\_\_\_\_  
\_\_\_\_\_

State the names of Municipality's employees whom you claim were at fault, including any information that will assist in identifying and locating them.

\_\_\_\_\_  
\_\_\_\_\_

e. State in detail each and every negligent or wrongful act of the Municipality and Municipal employees which caused your damages.

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

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

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4a. Claim for damages (Check appropriate block):

Bodily Injury       Property Damage       Other - Explain in detail \_\_\_\_\_  
\_\_\_\_\_

b. If you claim Bodily 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, or diagnostic service, state:

NAME OF HOSPITAL DOCTOR OR OTHER FACILITY	ADDRESS	DATES OF TREATMENT OR SERVICES	AMOUNT OF CHARGES TO DATE	AMOUNT PAID OR PAYABLE BY OTHER SOURCES SUCH AS INSURANCE

(4) 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 of return

NOTE: If your claimed loss of income arises from self-employment or other than wage attach a calculation showing the basis of your calculation of lost 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(2) The present location and time when the property may be inspected.

\_\_\_\_\_

(3) Date property acquired \_\_\_\_\_

(4) Cost of property \$ \_\_\_\_\_

(5) Cost 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.

d. Set forth in detail all other items of loss of damages claimed by you and the method by which you made the calculation.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- (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? \_\_\_\_\_  
If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.  
\_\_\_\_\_  
\_\_\_\_\_

- (7) Are any of the losses or expenses claimed herein covered by any police of insurance? \_\_\_\_\_  
For each such policy, state the names and addresses of the insurance company, policy number and benefits paid or payable.  
\_\_\_\_\_  
\_\_\_\_\_

- (8) Have you received or agreed to receive any money from anyone for the damages claimed? \_\_\_\_\_  
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 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 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 to be 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.

DATED: \_\_\_\_\_

\_\_\_\_\_  
Claimant or person filing claim on behalf of claimant

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals, or other medical service facilities to release to the City of Linden, its insurance carriers or its representatives any and all records, reports, and other information concerning the treatment of the claimant named herein.

DATED: \_\_\_\_\_

\_\_\_\_\_  
Signature

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

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April 7, 1992  
2nd & FINAL READING  
April 21, 1992

ORD. NO. 30-26

AN ORDINANCE ADOPTING A CLAIM FORM  
PURSUANT TO N.J.S.A. 59:8-6 FOR TORT  
CLAIMS AGAINST THE CITY OF LINDEN.

WHEREAS, N.J.S.A. 59:8-6 empowers a public entity to adopt forms specifying information to be contained in claims filed against it under the Tort Claims Act (N.J.S.A. 59:1-1 et seq.); and

WHEREAS, the Governing Body of the City of Linden determines it to be in the best interests of the City of Linden to adopt such forms to facilitate a full and fair review of such claims;

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE CITY OF LINDEN that the form attached hereto and made a part hereof by reference be and hereby is adopted as the official claim form by the City of Linden, which form shall be utilized by all claimants with respect to any claims presented against the City of Linden pursuant to N.J.S.A. 59:1-1 et seq.

PASSED: April 21, 1992

George H. Mulka  
President of Council

APPROVED: April 22, 1992

John T. Regorio  
Mayor

ATTEST:  
Dale J. ...  
City Clerk