CLAIM FOR DAMAGES AGAINST THE BOROUGH OF ROSELAND

THIS CLAIM FORM MUST BE COMPLETED AND RETURNED TO

Jock H. Watkins, Borough Clerk
Borough of Roseland
140 Eagle Rock Avenue
Roseland, NJ 07068
Phone: (973) 226-8080

WITHIN NINETY (90) DAYS OF
INCIDENT/OCCURRENCE OR YOU
MAY FORFEIT YOUR RIGHTS
PURSUANT TO N.J.S.A. 59:1 ET SEQ

① ***CLAIMANT INFORMATION***

_____ *$* _____
DATE OF OCCURRENCE *AMOUNT OF CLAIM*

_____ _____
LAST NAME, FIRST, MIDDLE *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*
describe Relationship _____

③ *Provide the following information with regard to the occurrence or incident that gives rise to this claim:*

a.
Date _____ *Time* _____

b. Describe the location or place of the occurrence.

_____ _____
Municipality *Exact location of the occurrence*

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

_____

_____

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

_____

_____

e. State the negligence or wrongful acts alleged and describe how each of the above named employees or agencies is responsible for each such negligent or wrongful act.

_____

_____

_____

f. Provide the name and address of all witnesses to the incident or occurrence.

_____

_____

_____

g. State the names of all police officers and police departments who investigated the incident.

_____

_____

_____

h. Did the loss occur during the course and scope of your employment? ( )Yes ( ) No

If Yes, please provide name and address of your employer:

_____

④ *Nature and description of damages alleged.*

(a) Indicate below the nature of damages which are claimed (check appropriate block)

( ) Property Damages
( ) Personal or Bodily Injury
*( ) Other-(Explain in detail):*_____

(b) If you claim bodily injury, complete and return with this Tort Claim Form fully signed HIPPA authorizations for each of your medical providers (please note that the required form is attached to this Tort Claim Notice)

(1) Describe your injuries resulting from this incident 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, provide:

I. Name of Hospital Doctor or other 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 list below the name and address of each carrier, named insured and policy number.

_____

_____

_____

Please list bill all bills submitted to each carrier.

(5) If you claim loss of wages or income as a result of the injury, complete and provide the attached form of "Authorization for Release of Employment Information", and state:

_____ _____

Name of Employer *address of Employer*

_____ _____

Your Occupation *Date you became employed at this job*

_____ _____

Rate of pay at time of injury *Dates of absence from work*

_____ _____

Total lost wages to date *If still out of work, expected date of return*

If injury is associated with an auto incident, please provide name of 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.

_____

c. If you claim property damage:

(1) Describe the property damaged.

_____

(2) Set forth below the current location of the damaged property and the time when it may be inspected.

_____

(3) Set forth the date the property was acquired by you: _____
(4) Set forth the value of the property at the time you acquired it: $_____

(5) Set forth the value of the property at the time of the incident:$_____

(6) Set forth a detailed description of the damage to the property:

_____

_____

(7) Has the damage been repaired? ( )Yes ( ) No

If Yes, please set forth below who made the repairs, the date of said repairs and the cost.

_____

_____

(8) *Attach each estimate and invoice for the above listed repairs to this form.*

_____

(9) *Describe in detail the loss claimed by you for property damage.*

_____

⑤ *State the total amount of damages (personal, property and other) you are claiming.*

_____

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 below the names and addresses of all persons against whom you have made such claims and the amounts recovered from each such person.

_____	_____
Name and address	*Amount recovered*
_____	_____
Name and address	*Amount recovered*
_____	_____
Name and address	*Amount recovered*

⑦ *Are any of the losses or expenses claimed herein covered by any policy of insurance?*
( )Yes ( ) No

If Yes, for each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable. Please attach copies of all denial or claim approval letters from such carriers.

_____

_____

_____

⑧ *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.*

_____

_____

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, repair estimates and invoices for the 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 and a fully executed copy of the form of "Authorization for Release of Employment Information" (see attached). If you are self-employed, provide a statement establishing the calculation of your claimed lost income.

(5) Fully completed HIPPA forms (see attached).

(6) Clear copies of any photographs in your possession or otherwise available to you which relate to any loss or damage claimed herein.

(7) Copies of all communications with insurance carriers who have been placed on notice of your loss.

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

Dated: _____ ***Print Name:*** _____

Signature : _____

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

HIPPA COMPLIANT AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____
ADDRESS: _____
_____
SS#: _____
DOB: _____

I hereby authorize the below physician/medical provider/hospital to release ANY AND ALL RECORDS IN THEIR POSSESSION PERTAINING TO ME, included but not limited to: medical office, and/or treatment records; office notes, treatment examination and/or consultation reports, diagnostic tests, x-ray, MRI and CT films and reports from: THE PAST (5) YEARS:

Provider Name and Address: _____
_____
_____
_____

This information may be disclosed to:

New Jersey Intergovernmental Insurance Fund Claims Department and/or its Representatives and Business Associates
c/o Cannon, Cochran Management Services, Inc.
P.O. Box 217
Linwood, NJ 08221

For the purpose of: I AM A CLAIMANT IN A PERSONAL INJURY MATTER.

I understand that have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office of the above-named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date: 6 months.

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need to sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about the disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information.

I understand that my heath records may include information pertaining to treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. If you do not wish this information to be released, please initial: DO NOT RELEASE_____.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representative's Authority Signature of Witness
(Witness signature required)

AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE NEW JERSEY INTERGOVERNMENTAL INSURANCE FUND CLAIMS DEPARTMENT OR ITS REPRESENTATIVES, AND ALL MEDICAL INFORMATION CONCERNING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING MY RATE OF PAY, JOB DESCRIPTION, DATES OF ABSENCES AND REASONS THEREFORE.

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

_____ _____

DATED SIGNATURE

_____

PRINT NAME AS SIGNED ABOVE