

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

TORT CLAIM FOR DAMAGES AGAINST THE CITY OF TRENTON

File Number: _____

Forward to: City Clerk for the City of Trenton
City Hall
319 E. State Street
Trenton, New Jersey 08608

Questions pertaining to Claims against the City of Trenton are to be forwarded to:

Department of Administration 609-989-3825
Law Department 609-989-3011

Claimant:

1.

LAST NAME FIRST MIDDLE

DATE OF BIRTH

STREET ADDRESS

MAILING ADDRESS

CITY STATE ZIP

SOCIAL SECURITY NUMBER

HOME PHONE

WORK PHONE

MARTIAL STATUS

NUMBER OF DEPENDENTS

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

2.

NAME

MAILING ADDRESS

Relationship to Claimant: Attorney at Law
Other specify _____

3. The occurrences of accident which gave rise to this claim.

A. _____
DATE

TIME A.M. P.M.

B. Describe the location or place of the accident or occurrence.

MUNICIPALITY _____

EXACT LOCATION OR OCCURRENCE INCLUDE EXACT
STREET, ADDRESS OR EXTENSION

C. Describe how the accident or occurrence happened.

D. Draw a diagram of the area of the incident. Label all intersecting streets. Indicate "North" by an arrow. Indicate house numbers where applicable. Mark "X" at exact spot of occurrence and state distance in feet from nearest intersecting streets if spot is not otherwise identifiable. Indicate public property.

E. State the name and address of the City Department, Division or Agency that you claim caused your damage/injury.

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

G. State the negligence or wrongful acts of the City entity and City employees which caused your damage. (Explain fully)

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

I. State the names and address of all police officers and police departments who investigated the accident.

4a. Claim for damages (check appropriate box)

Personal Injury

Property Damage

Other

If 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 accident or occurrence?

Yes

No

Explain in detail the nature and extent of all injuries claimed to be permanent disability

3) For each hospital, doctor, or other practitioner rendering treatment, examination or diagnostic service, state:

Name of Hospital Doctor or Other Facility	Address	Date of Treatment	Amt. of Charges to Date	Amt. Paid or Payable by Other Sources Such Insurance
---	---------	----------------------	-------------------------------	---

5. If you claim lost wages or income as a result of this injury, state:

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

YOUR OCCUPATION

DATE EMPLOYED AT THIS JOB

RATE OF PAY

DATES OF ABSENCE FROM WORK

TOTAL LOST WAGES TO DATE

IF STILL OUT OF WORK, EXPECTED RETURN DATE

NOTE: If your claimed loss of income arises from self-employment, or sources other than wages, attach an itemization showing the basis of your calculation of lost income.

6. Set forth any and all other losses claimed by you.

7. If you claim property damage:

a. Describe the property damaged

b. The present location and time when the property may be inspected.

c. Date property acquired: _____

d. Cost of Property: _____ Value at time of accident _____

e. Description of Damage: _____

f. Has the damage been repaired _____ If so, by whom, when and cost of repairs

g. Attach each estimate of repair costs to this form.

h. Describe in detail the loss claimed by you for property lost or damaged.

i. Describe in detail all other items of loss and wages claimed by you and the method by which you made the calculation.

8. **State the total amount of your claim** as of the date of the presentation of this claim. Include the estimated amount of any prospective injury, damage, or lost insofar as presently known. Set forth the basis of computation of the amount claimed if not already set forth herein:

9. Have you made a claim against anyone else (including insurance companies) for any of the losses or expenses claimed in this notice? Yes No

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claim.

10. Are any of the losses or expenses claimed herein covered by any policy of insurance? (This question must be answered even if you do not intend to make a claim against such insurance coverage) Yes No

For each policy, state the name and address of the insurance company, policy number and benefits paid or payable.

11. If this claim involves an automobile please state:

- a. Name of Insurance Company covering the automobile _____
- b. Name of Local Agent _____
- c. Policy Number and date of coverage _____

12a. State the name of your Homeowners' Insurance Company _____

- b. Name of Local Agent _____
- c. Policy Number and date of coverage _____

13. If you have any other form or kind of indemnity, casualty, comprehensive or liability insurance please state:

a. The name or names of the insurance company (ies) and policy number(s)

b. Type of coverage: _____

c. The name and address of your local insurance agent: _____

14. If you have received or agreed to receive any money from anyone for the damages claimed herein? Yes No If so, set forth the details of such agreement. *(including your own insurance coverage together with medical and hospitalization coverage)*

15. The following items must be submitted with this notice:

- 1) Copies of itemized bills for each medical expense or other losses and expenses claimed.
- 2) Full copies of all written reports of all expert witnesses and treating physicians.
- 3) Copies of all written reports or statements of all witnesses.
- 4) A letter from your employer verifying your lost wages. If self-employed a statement showing the calculation of your claimed lost income.

16. Please specify, if known, whether the claim arises out of the activities of any of the following agencies or authorities.

- Trenton-Mercer County War Memorial
- Trenton Housing Authority
- Trenton Public Library
- Trent House
- Neighborhood Community Center (explain)
- Trenton Commons
- Trenton Parking Authority
- Trenton Parking Utility
- Any School Property or School Playground (explain)
- Any Demolition Project (explain)
- Any Municipal Construction Project (explain)

17. State whether the incident has occurred on any sidewalk, street, or bridge located in the City of Trenton.

18. If yes, please give exact location _____

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 statements made herein is willfully false, that I am subject to punishment as provide by law.

Dated: _____

CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

TO WHOM IT MAY CONCERN:

I hereby authorize any and all physicians, hospitals or other medical service facility to release to the City of Trenton any and all records, reports and other information concerning the treatment of the claimant named herein. Photocopies of this signed authorization are permitted.

SIGNATURE

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

ALL INFORMATION REQUESTED IN THIS FORM MUST BE PROVIDED SO THAT FAIR AND FULL DISCLOSURE OF INFORMATION NECESSARY TO THE ORDERLY AND EXPEDIENT ADMINISTRATIVE DISPOSITION OF THE CLAIM MAY BE HAD. UNDER THE SCHEME OF THE NEW JERSEY TORT CLAIMS ACT, A GOVERNMENT ENTITY IS AFFORDED AT LEAST SIX MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETED CLAIM FORM TO REVIEW AND SETTLE MERITORIOUS CLAIMS. FAILURE TO PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS AND/OR THE WITHHOLDING OF INFORMATION MAY RESULT IN FORFEITURE OF THE CLAIMANT'S RIGHTS (N.J.S.A. 59:8-1, ET SEQ)