City of Vancouver Risk Management
415 W. 6th Street, P.O. Box 1995, Vancouver, WA 98668-1995
Email: riskandsafetyreporting@cityofvancouver.us
Phone: 360-487-8436

CLAIM FOR DAMAGES FORM

IMPORTANT: Please complete this form as completely as possible. Attach separate sheets if necessary.

PERSONAL INFORMATION

Full Name Date of Birth

Current Address City State Zip code

Home telephone number Mobile number

Address at time of incident (if different than above)

Email

Employer

If minor, name of parent or guardian

INCIDENT (TIME AND PLACE INJURY OR DAMAGE OCCURRED)

Date of Incident Time of Incident ☐a.m. ☐p.m.

Exact location of occurrence

Describe nature of incident (i.e., the conduct and circumstances that brought about the injury or damage) (Be as detailed as possible)

INJURY/DAMAGES

Nature of injury or property damage being claimed

Legal owner of property being claimed

Medical treatment received? Yes ☐ No ☐

Name of treating Doctor _____

Hospital treatment received? Yes ☐ No ☐

Name of Hospital _____

Are you covered by insurance? Please list your agent or carrier and policy #:

What is the amount of damages claimed? (Please include copies of receipts or estimates)

Have you filed a claim with anybody else? If so, with whom?

AUTOMOBILE CLAIMS ONLY

Name, address and telephone number of the owner of the vehicle involved, if different from operator:

WITNESSES (if any)

Name and contact information of all witnesses to incident:
(Attach separate sheets if necessary)

Name _____
Relation _____
Address _____
Phone No. _____

Name _____
Relation _____
Address _____
Phone No. _____

OTHER HELPFUL INFORMATION

Names and telephone numbers of all city employees having knowledge of this incident:

Name _____
Phone No. _____

Name _____
Phone No. _____

Describe why you believe the City of Vancouver caused your injuries or damages. If your damages were not caused by the City, do not use this form. You must file your claim against the correct entity.

VERIFICATION

This claim form must be signed either by: (a) the claimant, verifying the claim, (b) pursuant to a written power of attorney, by the attorney in fact for the claimant, (c) by an attorney admitted to practice law in Washington state on the claimant's behalf; or (d) by a court-approved guardian or guardian ad litem on behalf of the claimant.

(COMPLETE ONLY ONE SECTION)

CLAIMANT

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Date _____ **Place signed:**_____ **Signature** _____

ATTORNEY IN FACT

I declare under penalty of perjury under the laws of the State of Washington that I am an attorney in fact for the claimant and that I am authorized to present this claim on his/her behalf. (Attach copy of documentation supporting attorney in fact relationship).

Date _____ **Place signed**_____

Print Name _____ **Signature** _____

ATTORNEY AT LAW

I declare under penalty of perjury under the laws of the State of Washington that I am an attorney admitted to practice law in the State of Washington, am in good standing, and am authorized by the claimant, who is my client, to file this claim on his/her behalf.

Date _____ **Place signed**_____ **Signature** _____

Print Name _____**; WSBA No.**_____

COURT APPROVED GUARDIAN OR GUARDIAN AD LITEM

I declare under penalty of perjury under the laws of the State of Washington that I am a court-approved guardian or guardian ad litem for the claimant and am authorized to present this claim on his/her behalf. (Attach court documentation showing court approval of guardian/guardian ad litem appointment).

Date _____ **Place signed**_____

Print Name _____ **Signature** _____

HOW TO SUBMIT THIS FORM

Present in person or mail Tort Claim to one of the following Risk Management representatives:

Risk Manager, Brent Waddle, 360-487-8436
Claims Analyst, Tiffany Jodoin, 360-487-8434

Email: riskandsafetyreporting@cityofvancouver.us
Mail: PO Box 1995, Vancouver, WA 98668-1995
Delivery: 415 W. 6th Street, Vancouver, WA 98660

Business Hours: Monday - Friday 8 a.m. to 5 p.m. Closed on weekends and legal holidays
The City of Vancouver will accept e-mails, copies of, or other non-original Tort Claim Notices
This Tort Notice conforms with RCW 4.96.020
This claim form and other supporting documents filed with the City are considered public records under Washington's Public Records Act, ch. 42.56 RCW, and are therefore subject to disclosure to any third party upon request.

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www.cityofvancouver.us
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RE: MANDATORY INSURER REPORTING

Sir/Madam:

Please note that federal law[1] requires insurers and self-insured entities to report the resolution of most claims for bodily injury or medical expenses brought by Medicare beneficiaries or their representatives. Therefore, the City of Vancouver requests information from claimants to which the law may apply. You can find this requirement in the U.S. Code by using the following title and section number: Title 42, Section 1395Y(b)(8).

The attached Affidavit of Medicare Eligibility form must be completed and returned, along with the Claim for Damages form. Failure to provide this information may slow resolution of any claim you may have.

This information is needed even if you are not currently a Medicare beneficiary, so that we can demonstrate that we are screening each file to determine whether this report is needed or not.

We appreciate your assistance in complying with this federal mandate. Contact the undersigned with questions concerning this request.

Sincerely,

Brent Waddle
Risk Manager

[1] Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007

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AFFIDAVIT OF MEDICARE ELIGIBILITY FORM

Legal Name: First_____ M.I._____ Last_____

Gender: ☐Male ☐ Female

Social Security Number (SSN):_____

Maiden name or other names under which you have used the above SSN:

Are you represented by an attorney for the claim you submitted? ☐Yes ☐ No

If yes, please provide the following:

Attorney's name: _____

Attorney's address and telephone no.:

1. Have you reached the age of 64 and become entitled to receive either Social Security, Widow's/Widower or Railroad Retirement benefits? ☐Yes ☐No
2. If you are under the age of 64, have you received or applied for Social Security, Widow's/Widower's or Railroad Retirement benefits? ☐Yes ☐No
3. Have you treated for end stage renal disease that has required dialysis treatment of kidney transplant? ☐ Yes ☐ No
4. Are you currently receiving Medicare benefits? ☐ Yes ☐ No
5. Have you ever applied for Social Security Disability Insurance (SSDI)? ☐ Yes ☐ No
6. If SSDI accepted, what is the SSDI entitlement date?

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I may be subject to certain action by Medicare including but not limited to possible penalties and fines and/or recovery of any funds improperly paid to me by Medicare in connection with the above-referenced claim.

Signature _____ Date _____