BOROUGH OF
Kinnelon
130 Kinnelon Road
Kinnelon, New Jersey 07405

973-838-5401
Fax: 838-1862
www.kinnelonboro.org

CLAIMS FOR DAMAGES AGAINST THE BOROUGH OF KINNELON

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

(1) CLAIMANT INFORMATION

______________________	$ ______________________
DATE OF ACCIDENT	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 Relationship

③ *The occurrence or accident which gave rise to this claim:*

a. *Date:* *Time:*

b. *Describe the exact location or place of the occurrence*

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

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

e. *State the negligence or wrongful acts alleged and which of the above named employees or agencies you feel are responsible for each.*

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

g. *State the names 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,*

(1b*) Describe your injuries resulting from this accident or occurrence.*

(2b*) Do you claim Permanent disability resulting from this injury?*

( ) Yes *( )* No

If yes, describe the injuries believed to be permanent.

(3b*) 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 or
Service:

Amount of charges to
date:

(4b) *Are you covered by any health insurance policy? If so, please advise names and address of carrier, named insured and policy number.*

List bills submitted to carrier:

(5b) *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:*

If injury is associated with an auto accident, please provide name of auto insurance carrier and policy number

NOTE: *If your claimed lost of income arises from self employment or other than wages, attach a calculation showing the basis of your calculation of lost income.*

(6b) *Set forth any and all losses or damages claimed by you.*

c. *If you claim property damage:*

(1c) *Describe the property damaged*

(2c) *Present location and time when the property may be inspected*

(3c) *Date Property acquired*

(4c) *Cost of property $*

(5c) *Value of property at time of accident $*

(6c) *Description of damages*

(7c) *Has the damage been repaired?*
If so, by whom, when and cost of the repairs?

(8c) *Attach each estimate of repair cost to this form*

(9c) *Set forth 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?*

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 policy of insurance? For each such policy, state the name and address 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 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 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 the calculation of you 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 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 the law.

Dated:______________________ Print Name:______________________________
(claimant or person filing on behalf of claimant)

Signature:______________________________

MEDICAL EMPLOYMENT INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals, and or other medical service facilities to release to 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:

Dated:

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

COMPLETED FORM MUST BE FORWARDED TO: