File # _____

Clmt: _____

NOTICE OF CLAIM

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.

FORWARD TO: Borough of Totowa
537 Totowa Road
Totowa, NJ 07512

1. Claimant:

_____ _____
Last First Middle Phone Number

_____ _____
Street Address Additional Address

_____ _____
City, State, Zip Code Date of Birth Social Security No.

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

_____ _____
Last First Middle Phone Number

_____ _____
Street Address Additional Address

_____ _____
City, State, Zip Code Date of Birth Social Security No.

File # _____
Clmt: _____

3. A) 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

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, address of the Municipality or Agency that you claim caused your damage:

_____

_____

_____

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

_____

_____

_____

F) State in detail each and every negligent or wrongful act of the Municipality employees which caused your damage:

_____

_____

_____

_____

_____

File # _____
Clmt: _____

G) State the name and address of all witnesses to the accident or occurrence:

_____

_____

_____

_____

H) If vehicle accident, state the names, address, age and relationship to insured of all passengers in your vehicle:

_____

_____

_____

_____

I) State the names of all Police Officers and Police Departments who investigated the accident:

_____

_____

_____

_____

4. A) Claim for Damages (check appropriate box):

[ ] Bodily Injury [ ] Property Damage [ ] Other (Explain)

_____

_____

_____

_____

_____

B) 1) If you claim injury, describe your injuries resulting from this accident or occurrence:

_____

_____

_____

File # _____
Clmt: _____

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, state:

Name & Address of Hospital, Doctor or Other Facility	Dates of Treatment	Amount of Charged to Date	Amount Paid or Payable by Other Insurance

4) If you claim loss of wages or income as a result of the injury, state:

_____ _____
Name of Employer Address

_____ _____
Your Occupation Date Employed at this Job

_____ _____
Rate of Pay Dates of Absences from Work

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

5) Set Forth any and all other losses or damages claimed by you:

_____

_____

_____

File # _____
Clmt: _____

C) If you claim property damage:

1. Describe the property damaged; of vehicle, include make, model, year, color, vehicle identification number, license plate number, state and parts of vehicle damaged:

_____

_____

_____

_____

2. The present location and time the property can be inspected:

_____

_____

_____

_____

3. Date property was acquired:

_____

4. Cost of property:

_____

5. Value of property at the time of the accident:

_____

6. Description of damage:

_____

7. Has the damage been repaired? [ ] Yes [ ]No
If Yes, by whom, and cost of repairs:

_____

_____

_____

8. Attach each estimate of repair cost to this form.

File # _____
Clmt: _____

9. Set forth in detail the loss claim by you for property damage:

_____

_____

_____

D) Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculations:

_____

_____

_____

5. The amount of claim:

_____

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 the names and addresses of all persons and the insurance companies against who you have made such claims:

_____

_____

_____

7. Are any of the losses or expenses claimed herein covered by any policy of insurance? [ ] Yes [ ] No

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 agree to receive any money from anyone for damages claimed herein?
[ ] Yes [ ] No If yes, set forth the details of such agreement:

_____

_____

_____

_____

File # _____
Clmt: _____

9. THE FOLLOWING ITEMS MUST BE SUMBITTED 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 reading physicians.
4. A letter from your employer verifying your lost wages. If Self-employed, a statement showing calculations of your 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 one known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

_____ _____
Date Claimant or Person filing on behalf of Claimant

_____
Print Name As Signed Above

File # _____
Clmt: _____

HIPPA COMPLIANT AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION

PLEASE PROVIDE AN AUTHORIZATION FOR EACH MEDICAL PROVIDER

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

I hereby authorize the below listed 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 test results, x-ray, MRI and CT films and reports from: THE PAST FIVE (5) YEARS.

Provider Name and Address: _____
_____
_____

This information may be disclosed to:
The Garden State Municipal Joint Insurance Fund Claims Department and/or its Representatives

C/O Qual-Lynx, Inc.
100 Decadon Drive
Egg Harbor Township, NJ 08234

For the purpose of: I AM A CLAIMANT IN A PERSONAL INJURY MATTER,
I understand that I 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 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 health 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)

File # _____
Clmt: _____

AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE GARDEN STATE MUNICIPAL JOINT INSURANCE FUND CLAIMS DEPARTMENT OF ITS REPRESENTATIVES ANY AND ALL MEDICAL INFORMATION CONCERNING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING RATE OF PAY, DUTIES TO BE PERFORMED, DATES OF ABSENCES AND REASONS THEREFORE.

A PHOTOCOPY OF THIS DOCUMENT WILL BE ACCEPTABLE AS AN ORIGINAL

_____ _____
DATE SIGNATURE

_____
PRINT NAME AS SIGNED ABOVE