The following items may be helpful in the determination of this claim:

- **Police/Accident Report**
- **Estimate for Damages**
- **Pictures of Damage (may include location of incident/accident)**
- **Receipts (out–of–Pocket expenses)**
- **Insurance - Declaration Page**

If you require any additional information, you may contact our office at (908) 820-4009.

Please return this claim form to:
City Hall
50 Winfield Scott Plaza
Law Department, Room 201
Elizabeth, New Jersey 07201

Amended 8/2013

CLAIM FORM REQUIRED BY THE CITY OF ELIZABETH PURSUANT TO N.J.S.A. 59:1-1, ET SEQ. THE NEW JERSEY TORT CLAIMS ACT

1. Name of Claimant:_____

   Address: _____

   Social Security Number: _____

   Phone Number :( )_____

2. Post Office Address to which Claimant desires notices and correspondence to be sent:

   _____

   _____

3. The date, location and other circumstances of the occurrence which gave rise to the claim asserted herein:

   _____

   _____

   _____

   _____

4. General description of the injury, damage or loss incurred to date:

   _____

   _____

   _____

5. The name(s) of the public entity/entities and/or employee(s)causing the alleged injury, damage or loss if known:

   _____

   _____

6. The amount claimed as of the date of this form, including the estimated amount of any prospective injury, damage or loss, as may be known at this time, with the basis of the computation of this amount:

   _____

7. State, in detail, the facts upon which you rely to support your allegation that the City of Elizabeth is responsible or liable for the injuries, damage or loss incurred by claimant:

   _____

   _____

   _____

8. Provide the name(s) and address(es) of all medical providers, including hospitals, physicians, clinic=s, health care organizations or health care employees who treated the claimant for injuries alleged to have occurred as a result of the incident claimed herein:

_____

_____

_____

9. Attach copies of written reports of the claimant=s attending physician(s) or dentist setting forth the nature and extent of the injury and the treatment, any degree of permanent or temporary disability, the prognosis, period of time hospitalized, any diminished earning capacity, duration of pain and suffering, if claimed and any drugs administered for pain (please see attached medical disclosure form).

10. List claimant=s expert witnesses and attach any reports or statements relating to the claim prepared by those experts:

_____

_____

11. Attach all itemized bills for medical, dental and hospital expenses incurred or all itemized receipts of payment for such expenses.

12. Attach documentation evidencing the amounts of any income which has been lost and attach written statement from any employer(s) showing actual time lost from employment, whether claimant is a full or part-time employee and the wages or salary actually lost.

13. State the anticipated expense for any future treatments, if necessary:

_____

14. If the claim is one of injury to or loss of property, real or personal, attach documentation evidencing proof of ownership of the property, a detailed statement of the amount claimed, an itemized receipt of payment for necessary repairs or itemized written estimates of the cost of such repairs, and a statement listing the date of purchase, purchase price and salvage value, whether repair is not economical.

15. If the claim is one based upon death, submit the following:

(a) An authenticated death certificate;

(b) Decedent=s employment or occupation at the time of death, including monthly or yearly salary or earnings and the duration of last employment or occupation.

(c) Name(s), address(es), birth date(s), kinship and marital status of decedent=s survivors.

(d) Degree of support afforded by decedent to each survivor dependent upon him for support at the time of death.

(e) Decedent=s general physician and mental condition before death.

(f) Itemized bills for medical and burial

16. Set forth the days and time when the Claimant is available, excluding weekends and evenings, for the physical examinations by a physician on behalf of the City.

_____

_____

17. Provide any pictures, diagrams and/or any other documents that the claimant or claimant=s attorney will rely on showing the location of the accident, the loss, the conditions of the property and/or the alleged damage to the property.

18. Name of all insurance carriers and the policy numbers which may pay or reimburse the claimant for any expenses incurred for treatment or repair:

_____

_____

Date submitted:_____

_____
Signature of Claimant

(See attached Authorization for Health Information Disclosure attached hereto and made a part hereof this claim form)

Authorization for release of personal and health Information

A. Member whose information is to be released

Member name		Date of birth ____/____/____
Address		
City	State	ZIP code
Contract number ID card	Phone	

I request and authorize the release of my personal and health information. This may include claims and billing information. It may also include medical records that have been received from medical practitioners, including records regarding general medical care, alcohol and drug abuse treatment, psychological or psychiatric treatment, social services counseling, human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or AIDS-related complex (ARC), communicable diseases or infections, venereal disease, tuberculosis, hepatitis and demographic information.

B. Type of information Priority Health may release (check ONE box)

☐ All of my information (including personal, health, demographic, claims, billing and medical records) OR
☐ Only my claims and billing information OR
☐ Other, such as information regarding a specific date of service or issue (explain) _____

C. Who may receive your information?

Individual/entity name		Phone
Address		
City	State	ZIP code

D. What is the purpose of this Authorization? (check ONE box)

☐ At my request
☐ Other (explain) _____

E. When will this Authorization expire? (check ONE box)

Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed.

☐ No expiration
☐ Upon my coverage termination
☐ On the following date ____/____/____ (MM/DD/YYYY)
☐ Upon my death
☐ Upon my written revocation
☐ On the following event _____

I understanding that I may refuse to sign this Authorization, I may revoke this Authorization at any time by notification in writing at the address listed below. The revocation will not be effective for information that has been disclosed between the time that this Authorization is signed and when the revocation is received. I understand that I have the right to receive a copy of this Authorization after I sign it. I understand that the persons to who information is disclosed under the Authorization may possibly redisclose the information to others without my knowledge or consent, and therefore, the privacy of my personal and health information may no longer be protected by law.

F. Signature required

If signed by a person other than the member, please check the relationship and provide proof of authority to do so:

☐ Parent of a minor child
☐ Power of attorney
☐ Legal guardian
☐ Personal representative of deceased member

Signature	Date ____/____/____
Printed name	

G. Finalize and send

- Form must be fully completed
- Submit form via one of the following
  - Scan and email to: mfigueiredo@elizabethnj.org
  - Fax to: 908.352.8658
  - Mail to: City of Elizabeth, Law Department, 50 Winfield Scott Plaza, Elizabeth, New Jersey 07201

This form satisfies all required elements of elements of a valid authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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 not 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 concerning disclosure of my health information, I may contact the City of Elizabeth Law Department.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, AIDS, 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

_____ _____
Witness Signature of Witness