

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 COPIES TO:

1. Inservco Insurance Services
P.O. Box 1457
Harrisburg, PA 17105

2. Borough of Roselle Park
110 East Westfield Avenue
Roselle Park, NJ 07204

1) CLAIMANT : _____
last first middle

PHONE # _____
area code/phone #

_____ street address

_____ additional address

_____ city state zip code

_____ d/o/b ss# .

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 # _____
area code/phone #

_____ street address

_____ additional address

_____ city state zip code

_____ relationship to claimant

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 AND 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 AND MUNICIPAL EMPLOYEES WHICH CAUSED YOUR DAMAGE.

g. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO THE ACCIDENT OR OCCURRENCE

h. IF VEHICLE ACCIDENT, STATE THE NAMES, ADDRESSES, 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 BODILY INJURY, DESCRIBE YOUR INJURIES RESULTING FROM THIS ACCIDENT OR OCCURRENCE.

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:

<u>NAME AND ADDRESS OF HOSPITAL, DOCTOR, OR OTHER FACILITY</u>	<u>DATE OF TREATMENT</u>	<u>AMOUNT OF CHARGE TO DATE</u>	<u>AMOUNT PAID OF PAYABLE BY OTHER INSURANCE</u>
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A)

B)

C)

D)

