

INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST

FORWARD TO:

Burlington County Board of County Commissioners
c/o Division of Insurance & Risk Management
49 Rancocas Road; RM 224
P.O. Box 6000
Mount Holly, NJ 08060-6000

This form must be filed within 90 days of this accident or you may forfeit your rights.

1.

Name of Claimant

Date of Birth

Street Address

Medicare/Medicaid Recipient: ()Yes ()No
If yes, provide Medicare Health Ins. Claim # (HICN):

City State Zip

Social Security Number

Home Telephone Business Telephone

2.

If it is requested that notices be sent to a person other than the claimant, such as your attorney, please send notices to:

Name of Person

Mailing Address

Attorney at Law () or Other:
Relationship to Claimant

City State Zip

3.

Circumstances regarding the occurrence or accident:

Date and Time

Location

City

State

4.

Describe the accident or occurrence:

5. State the names and addresses of all witnesses to the above occurrence:

6. State the names and addresses of the public entity, or entities, that you claim caused your damage:

7. State the names and addresses of all other persons, companies, or governmental agencies whom you claim are responsible for your injuries or damages:

8. Briefly describe the injury, damages, and losses incurred by you:

9. Give the amount that you claim in damages: \$ _____

Give the basis for calculation of the above damages:

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

Dated: _____

Claimant or person filing claim on behalf of
Claimant