Notice of Claim Instructions

If you wish to make a claim against the Township of Montclair, please read the following information:

The Township of Montclair is protected from Tort actions by State Statute Title 59, and more specifically, Chapter 9, Paragraph 2e. Simply stated, Title 59: 9-2e means that, if you have insurance to cover "physical damage" to your property, the money you are entitled to receive under such policy of insurance shall be deducted from your claim against the Township.

To expedite settlement of your claim, we ask that you settle your physical damage with your physical damage insurance carrier.

You may submit a claim for your deductible by forwarding a copy of your estimate and a copy of the declaration sheet showing the amount of your physical damage deductible to the address listed below.

If you do not have "physical damage" coverage and wish to submit a claim, please forward an estimate for the damage, a copy of the declaration sheet from your insurance policy, and complete the enclosed Tort claim form.

Since all claims which are filed against the Township of Montclair must be filed within 90 days of their occurrence, we suggest that your documentation be sent via certified mail. Although this is not required, it will insure that you have proof of receipt by this office.

Should our investigation reveal that the Municipality is liable for your damage, you will be compensated.

Please allow a minimum of 90 days for a reply to your claim submittal.

Mail your response to:

Township Clerk
Township of Montclair
205 Claremont Avenue
Montclair, New Jersey 07042

NOTICE OF CLAIM FOR DAMAGES AGAINST THE TOWNSHIP OF MONTCLAIR

FORWARD TO: TOWNSHIP CLERK
TOWNSHIP OF MONTCLAIR
205 CLAREMONT AVENUE
MONTCLAIR, NEW JERSEY 07042
PHONE: (973) 509-4900

FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. CLAIMANT:

_____ _____ _____ _____
LAST NAME **FIRST** **MIDDLE** **DATE OF BIRTH**

_____ _____
STREET ADDRESS **MAILING ADDRESS IF OTHER THAN STREET ADDRESS**

_____ _____ _____
CITY **STATE** **ZIP CODE**

2. IF NOTICES AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, COMPLETE ITEM #2.

_____ _____
NAME **MAILING ADDRESS**

_____ _____ _____ _____
CITY **STATE** **ZIP CODE**

RELATIONSHIP TO CLAIMANT: ATTORNEY AT LAW ☐ **OR** _____
EXPLAIN RELATIONSHIP

THE OCCURRENCE OR ACCIDENT WHICH GAVE RISE TO THIS CLAIM:

3a.

_____ _____
DATE **TIME**

b. DESCRIBE THE LOCATION OR PLACE OF THE ACCIDENT OR OCCURENCE.

_____ _____
MUNICIPALITY **EXACT LOCATION OF THE OCCURRENCE**

c. DESCRIBE HOW THE ACCIDENT OR OCCURENCE HAPPENED: IF A DIAGRAM WILL ASSIST YOUR EXPLANATION, PLEASE USE THE REVERSE SIDE OF THIS FORM.

d. STATE THE NAME AND ADDRESS OF THE MUNICIPAL AGENCY OR AGENCIES THAT YOU CLAIM CAUSED YOUR DAMAGE.

STATE THE NAMES OF MUNICIPAL EMPLOYEES WHOM YOU CLAIM WERE AT FAULT, INCLUDING ANY INFORMATION THAT WILL ASSIST IN INDENTIFYING AND LOCATING THEM.

e. STATE THE NEGLIGENCE OR WRONGFUL ACTS OF THE MUNICIPAL AGENCY AND MUNICIPAL EMPLOYEES WHICH CAUSED YOUR DAMAGES.

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 THIS ACCIDENT.

4a. CLAIM FOR DAMAGES (CHECK APPROPRIATE BLOCK):

☐ PERSONAL INJURY ☐ PROPERTY DAMAGE

☐ OTHER - EXPLAIN IN DETAIL

b. IF YOU CLAIM PERSONAL INJURY:

(1) 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 SERVICES, STATE:

NAME OF HOSPITAL, DOCTOR OR OTHER FACILITY	ADDRESS	DATES OF TREATMENT OR SERVICE	AMOUNT OF CHARGE TO DATE	AMT. PAID OR PAYABLE BY OTHER SOURCE SUCH AS INSURANCE

(4) IF YOU CLAIM LOSS OF WAGE OR INCOME AS A RESULT OF THE INJURY STATE:

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

YOUR OCCUPATION

DATE YOU BECAME EMPLOYED

RATE OF PAY

DATE OF ABSENCE FROM WORK

TOTAL LOSS WAGES TO DATE

IF STILL OUT, EXPECTED DATE OF RETURN

NOTE: IF YOUR CLAIMED LOSS OF INCOME ARISES FROM SELF-EMPLOYMENT OR OTHER THAN WAGE, ATTACH A CALCULATION SHOWING THE BASIS OF YOUR CALCULATION OF LOST INCOME.

(5) SET FORTH ANY AND ALL OTHER LOSSES OR DAMAGE CLAIMED BY YOU.

_____

_____

C. IF YOU CLAIM PROPERTY DAMAGE:

(1) DESCRIBE THE PROPERTY DAMAGED.

_____

_____

_____

(2) THE PRESENT LOCATION AND TIME WHEN THE PROPERTY MAY BE INSPECTED.

_____

(3) DATE PROPERTY ACQUIRED. _____

(4) COST OF PROPERTY $ _____

(5) VALUE OF PROPERTY AT TIME OF ACCIDENT: $ _____

(6) DESCRIPTION OF DAMAGE.

_____

_____

(7) HAS THE DAMAGE BEEN REPAIRED? _____ **IF SO, BY WHOM, WHEN AND COST OF REPAIRS.**

_____

_____

(8) ATTACH EACH ESTIMATE OF REPAIR COSTS TO THIS FORM.

(9) SET FORTH IN DETAIL THE LOSS CLAIMED 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 CALCULATION.

_____

_____

5. **THE AMOUNT OF THE CLAIM.** _____

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 NAME AND ADDRESS 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?**

☐ YES ☐ NO

IF YES, SET FORTH THE DETAIL 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 YOUR LOST WAGES. IF SELF-EMPLOYED, A STATEMENT SHOWING THE CALCULATION OF YOUR 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 TO BE 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 LAW.

_____ _____

DATE **CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT**

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals or other medial service facilities to release to the TOWNSHIP OF MONTCLAIR or its representatives any and all records, reports, and other information concerning the treatment of the claimant named herein. Photocopies of the Authorization carry the same Authority as the original.

Dated: _____ Signature: _____

AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

TO WHOM IT MAY CONCERN:

I hereby authorize _____ to release any and all information concerning my employment, past and present, including rate of pay, duties performed, dates of absences and reasons therefore. Photocopies of this Authorization carry the same Authority as the original.

Dated: _____ Signature: _____