COUNTY OF HUDSON
LAW DEPARTMENT
OFFICE OF RISK MANAGEMENT
595 COUNTY AVENUE, SECAUCUS, NEW JERSEY 07094

Thomas De Gise
County Executive

Jaymme Harney
Risk Manager
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FAX: (201)795-6428

Donato J. Battista, Esq.
Hudson County Counsel

Date _____

To _____

Enclosed please find the County of Hudson Notice of Claim Form. This form is being sent to you because you claim to have suffered a loss allegedly caused by the county of Hudson. Pursuant to the provisions of the New Jersey Tort Claims Act, this form is required for filing of claims in accordance with N.J.S.A. 59:8.1 et seq. The questions are to be answered to the extent of all information available to the claimant or his/her attorney. In the event that some of the questions may not be applicable to your particular claim please indicate "Not Applicable" where appropriate.

Please note that **a copy of a police report must accompany the completed form** and photos of the area and/or damages are strongly recommended. N.J.S.A 59:9-2 provides that if there are policies of insurance which would cover all or part of your loss, you can only claim damage which is not covered by insurance. Therefore if this claim involves an automobile, you **must** include a copy of the cover page of your current auto insurance policy. Please describe in full and complete detail the factual basis for your cause of action.

This Claim Form, along with all supporting documentation, must be delivered to this office within 90 days of the loss. Failure to do so (within that period) will result in your claim being barred pursuant to N.J.S.A.59:1 et seq.

Respectfully,

Risk Management

Hudson County Office of Risk Management

COUNTY OF HUDSON

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF ACCIDENT OR OCCURRENCE OR YOU MAY FORFEIT YOUR RIGHTS. (N.J.S.A 59:8-1,et seq.)

CLAIM FOR DAMAGES AGAINST THE COUNTY OF HUDSON

Forward completed form to:

Hudson County Law Department
Attn: Investigations Unit
Administration Annex
567 Pavonia Avenue
Jersey City NJ 07306

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1. CLAIMANT:

Last Name First M.I. Date of Birth

Street Address Mailing Address

City State Zip Code City State Zip Code

Social Security Number Marital Status

Number of Dependents Home Phone No. Work Phone No.

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

Name Mailing Address

City State Zip Code

Relationship to Claimant: Attorney-at-Law{} or _____
Relationship

3. The occurrence or accident which gave rise to this claim.

Date _____ Time _____ A.M / P.M

Describe the location or place of the accident or occurrence. (Indicate exact street address)

Municipality _____ Exact Location _____

City _____ State _____ Zip Code _____

DESCRIPTION OF ACCIDENT

(A) Draw a diagram of the area of the incident. Label all intersecting streets, indicate "North" by an arrow. Indicate house numbers where applicable. Mark "X" at exactly the spot of the occurrence and state the distance in feet from nearest intersecting streets. If spot is not otherwise identifiable, indicate public property.

(B) State the name and address of the County agency or agencies that you claim caused you damage/injury

(C) State the names of the county employees who you claim were at fault, including any information that will assist in identifying and locating them.

_____

_____

_____

(D) State the negligence or wrongful acts of the County agency and County employees which caused your damage.

_____

_____

(E) State the name and address of all witnesses to the occurrence.

_____

_____

_____

(F) State the name and address of all police officers and police departments who investigated the incident.

_____

_____

_____

4. Claim for damages (check appropriate box):

{ } Personal Injury { } Property Damage { } Other

(A) If you claim **Personal Injury:**
(1). Describe your injuries resulting from this incident.

_____

_____

(2). Do you claim permanent disability resulting from this injury? _____ (Yes/No)

(3). For each hospital, doctor, or other practitioner rendering treatment, examination, or diagnostic state:

a). Name and address of hospital and/or doctor.

_____

_____

b). Date(s) of treatment:

_____

_____

c). Amount of charges to date _____

d). Amount paid of payable by other sources such as insurance _____

(4). If you claim lost wages or income, as a result of injury, state:

_____
Name and Address of Employer

_____
Your Occupation and Date Employed at this Job

_____ _____
Rate of Pay Date of Absences from Work

_____ _____
Total Lost Wages to Date Is still out of Work, Expected Date of Return

NOTE: If your claimed loss of income arises from self-employment or sources other than wages, attach an iternization showing the basis of your calculation of lost income

(5). Set forth any and all losses claimed by you _____

(B). If you claim **Property Damages:**

(1). Describe the property damaged. _____

_____

_____

(2) The location and time when property may be inspected.

_____

(3) Date property acquired. _____

a). Cost or property. _____

b). Value of property at time of accident. _____

c). Description of Damage. _____

_____

_____

d). Attach each estimate of repair costs to this form

e). Set forth in detail the list claimed by you for property damage.

_____

_____

f). Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

_____

_____

g). The total amount of the claim

_____

(C) If Other, explain in detail:

_____

_____

_____

_____

_____

5. Have you made a claim against anyone (including insurance companies) 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 insurance companies whom you have made such claim.

_____

_____

_____

6. Are any of the losses or expenses claimed herein covered by any policy of insurance

_____ (Yes/No)

If so, for each policy, state the name and address of the insurance company, policy number and benefits paid or payable.

_____

_____

_____

_____

7. Have you received or agreed to receive any money from anyone for the damages claimed herein?

_____ (Yes/No)

If so, set forth the details of such agreement. _____

_____

8. The following items must be submitted with this notice.

(a) Copies of itemized bills for each medical expense or other losses and expenses claimed.

(b) Full copies of appraisals and estimates of property damage claimed by you.

(c) Copies of all written reports of all expert witnesses and treating physicians.

(d) 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, I am subject to punishment provided by law.

Dated:_____ _____

Claimant or person filing on Behalf of Claimant

{Document Continues on Page 9}

TO WHOM IT MAY CONCERN

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to the County of Hudson any and all records, reports and other information concerning the treatment of the claimant named herein.

_____

Signature of Claimant

This form must be signed by claimant or the parents of the claimants who are minors

ALL INFORMATION REQUESTED IN THIS FORM MUST BE PROVIDED SO THAT FAIR AND FULL DISCLOSURE OF INFORMATION NECESSARY TO THE ORDERLY AND EXPEDIENT ADMINISTRATIVE DISPOSITION OF THE CLAIM MAY BE HAD UNDER THE SCHEME OF THE NEW JERSEY TORT CLAIMS ACT, A GOVERNMENTAL ENTITY IS AFFORDED AT LEASE SIX (6) MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETED CLAIM FORM TO REVIEW AND SETTLE MERITORIOUS CLAIMS. FAILURE TO PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS, OR TO RETURN THIS FORM IN A TIMELY MANNER, MAY ADVERSELY AFFECT THE CLAIMANT'S RIGHTS, PURSUANT TO N.J.S.A. 59:8-1, et seq.