OFFICE OF THE COUNTY COUNSEL

Hall of Records, Room 535, Newark, New Jersey 07102
973.621.5003 --- 973.621.4599 (Fax)
www.essexcountynj.org

Joseph N. DiVincenzo, Jr.
Essex County Executive

Jerome M. St. John
Essex County Counsel

NOTICE OF CLAIM FORM

FAXES & EMAILS WILL NOT BE ACCEPTED

PLEASE RETURN BY HAND-DELIVERY, CERTIFIED AND/OR REGULAR MAIL

TO: OFFICE OF THE COUNTY COUNSEL
HALL OF RECORDS – ROOM 535
465 DR. MARTIN LUTHER KING, JR. BLVD.
NEWARK, NEW JERSEY 07102

THE COUNTY OF ESSEX IS A PUBLIC ENTITY AND ANY CLAIMS SUBMITTED ARE GOVERNED BY THE NEW JERSEY TORT CLAIMS ACT, N.J.S.A. 59:1-1, *et seq*. AND THEREFORE SUBJECT TO THE REGULATIONS, DEFENSES, AND IMMUNITIES CONTAINED THEREIN.

CLAIMS MUST BE PRESENTED WITHIN NINETY (90) DAYS FROM THE DATE OF THE ALLEGED OCCURRENCE/INCIDENT. FAILURE TO COMPLY WITH THIS REQUIREMENT MAY RENDER YOUR CLAIM INVALID. (N.J.S.A. 59:8-8)

FAILURE TO COMPLETELY EXECUTE THIS FORM OR SUPPLY THE REQUESTED INFORMATION HEREIN MAY RENDER YOUR CLAIM INVALID AND FORFEIT YOUR RIGHT TO RECOVERY.

A. NAME OF CLAIMANT _____

ADDRESS _____

CITY _____ STATE_____ ZIP _____

TELEPHONE # _____ BETWEEN 9 A.M. AND 5 P.M. _____

DATE OF BIRTH _____ SOCIAL SECURITY # (LAST 4)_____

Revised 10/13/2022
Computer Forms:ks

Putting Essex County First

B. IF NOTICES AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, PLEASE STATE:

NAME OF REPRESENTATIVE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____

RELATIONSHIP, IF ANY _____

C. DATE AND TIME OF ACCIDENT OR OCCURRENCE WHICH GAVE RISE TO THIS CLAIM?

_____

D. STATE THE WEATHER CONDITIONS (IF APPLICABLE) _____

E. STATE THE EXACT LOCATION OF THE ACCIDENT OR OCCURRENCE.
PROVIDE LANDMARKS, INTERSECTING STREETS, INDICATE ANY PUBLIC PROPERTY, AND FULL ADDRESSES.

_____

_____

_____

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

_____

_____

_____

G. IF APPLICABLE, PLEASE STATE THE OBJECT WHICH CAUSED THE ACCIDENT OR OCCURRENCE.

_____

OBJECT'S LOCATION _____

H. (a) STATE THE NAME AND ADDRESS OF THE COUNTY AGENCY OR AGENCIES YOU CLAIM ARE RESPONSIBLE FOR YOUR DAMAGES OR INJURIES.

_____

_____

(b) STATE THE NAME OF ANY COUNTY EMPLOYEES YOU CLAIM WERE AT FAULT, INCLUDING ANY INFORMATION THAT WILL ASSIST IN IDENTIFYING OR LOCATING THEM.

_____

_____

I. STATE THE NEGLIGENCE OR WRONGFUL ACTS OR OMISSIONS OF THE COUNTY AGENCY AND/OR COUNTY EMPLOYEES WHICH YOU ALLEGE CAUSED YOUR DAMAGES.

_____

_____

J. STATE THE NAMES OF ALL POLICE OFFICERS, POLICE DEPARTMENTS, OR AGENCIES WHO INVESTIGATED OR ASSISTED WITH THIS ACCIDENT OR OCCURRENCE.

_____

_____

K. STATE THE NAMES, ADDRESSES AND TELEPHONE NUMBERS OF ALL WITNESSES TO THE ACCIDENT OR OCCURRENCE.

_____

_____

_____

L. CLAIM FOR DAMAGES: CHECK APPROPRIATE BLOCK

☐ PERSONAL INJURY

☐ PROPERTY DAMAGE

☐ OTHER – EXPLAIN IN DETAIL

_____

_____

M. IF YOU CLAIM PROPERTY DAMAGE:

1. DESCRIBE THE PROPERTY DAMAGE.

_____

_____

_____

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

_____

3. DATE PROPERTY WAS ACQUIRED _____

4. COST OF PROPERTY AT TIME IT WAS ACQUIRED_____

5. VALUE OF PROPERTY AT THE TIME OF INCIDENT OR OCCURRENCE AND THE METHOD BY WHICH YOU MADE THE CALCULATION _____

_____

6. HAS THE DAMAGE BEEN REPAIRED; IF SO BY WHOM, WHEN, AND COST OF REPAIRS.

_____

_____

_____

7. WAS AN INCIDENT OR POLICE REPORT FILED? IF YES, ATTACH A COPY_____

8. HAVE YOU OR SOMEONE ON YOUR BEHALF MADE A CLAIM AGAINST ANYONE ELSE FOR THE LOSSES CLAIMED IN THIS NOTICE? IF SO, IDENTIFY ALL PERSONS, AGENCIES, AND INSURANCE COMPANIES AGAINST WHOM YOU HAVE MADE SUCH A CLAIM.

_____

_____

_____

9. STATE THE NAME, POLICY NUMBER AND DEDUCTIBLE OF ANY INSURANCE POLICY INCLUDING AUTOMOBILE, HOMEOWNERS AND/OR RENTERS INSURANCE WHETHER OR NOT YOU BELIEVE THE POLICY WOULD ULTIMATELY COVER THE DAMAGES YOU CLAIM IN THIS NOTICE.*****

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***DISCLAIMER: Please be advised that the County of Essex is a public entity and protected by Title 59 "Tort Claims Act," specifically N.J.S.A. 59:9-2(e) which mandates that if you have insurance that covers "physical damage" to your property, you must disclose such information. 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 declaration sheet showing the amount of your physical damage deductible and an estimate of the damage along with this completed form. If you do not have "physical damage" coverage and wish to submit a claim, please forward an estimate of the damage and a copy of your declaration sheet from your insurance policy along with this completed form.**

N. IF YOU CLAIM PERSONAL INJURY:

1. DESCRIBE FULLY ALL INJURIES RESULTING FROM THIS ACCIDENT OR OCCURRENCE:

_____

_____

_____

_____

_____

_____

2. DO YOU CLAIM PERMANENT DISABILITY RESULTING FROM THIS INJURY?
IF YES, DESCRIBE THE INJURIES YOU BELIEVE TO BE PERMANENT.

_____

_____

_____

3. FOR EACH HOSPITAL, DOCTOR, OR OTHER MEDICAL HEALTH PROFESSIONAL WHO RENDERED TREATMENT, EXAMINATION OR DIAGNOSTIC TESTING IN CONNECTION WITH YOUR INJURY, PLEASE COMPLETE THE FOLLOWING:

NAME OF HOSPITAL OR OTHER FACILITY	**ADDRESS**	**DATES OF TREATMENT OR SERVICE**	**AMOUNT OF CHARGE TO DATE**	**AMOUNT PAID/PAYABLE BY OTHER SOURCES SUCH AS INSURANCE**

O. ARE YOU CLAIMING LOST TIME/WAGES OR OTHER INCOME? _____
IF YES, STATE:

1. NAME AND ADDRESS OF YOUR EMPLOYER_____
   _____
2. YOUR OCCUPATION_____
3. DATE YOU BECAME EMPLOYED_____
4. DATE OF ABSENCE FROM WORK_____
5. RATE OF PAY_____
6. TOTAL LOST WAGES TO DATE_____
7. IF STILL OUT, ANTICIPATED RETURN DATE_____

P. DID THIS ACCIDENT OR OCCURRENCE OCCUR IN THE COURSE OF YOUR EMPLOYMENT?

IF YES, STATE EMPLOYER'S NAME AND ADDRESS

_____

_____

_____

WORKERS COMPENSATION CARRIER AND EMPLOYER REPRESENTATIVE_____

_____

_____

Q. HAVE YOU RECEIVED OR AGREED TO RECEIVE ANY MONEY FROM ANYONE FOR ANY DAMAGES CLAIMED HEREIN? IF SO, SET FORTH THE DETAILS OF SUCH AGREEMENT AND THE PARTIES THERETO.

_____

_____

_____

SEE INTRUCTIONS ON THE FOLLOWING PAGE

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE

1) IF YOU ARE MAKING A **PROPERTY/AUTOMOBILE DAMAGE CLAIM**, ALONG WITH THE COMPLETED FORM, PLEASE ENCLOSE THE FOLLOWING:
   a) INCIDENT REPORTS
   b) ESTIMATES, APPRAISALS AND/OR REPAIRS
   c) COPIES OF ALL INSURANCE POLICY(IES) DECLARATION PAGE
   d) PROOF OF OWNERSHIP
   e) ANY RECEIPTS OR OTHER TYPE OF DOCUMENTED PROOF OF THE VALUE OF THE PROPERTY WHEN ACQUIRED
   f) PHOTOGRAPHS, VIDEOS, OR ANY OTHER TYPE OF DOCUMENTATION TO SUPPORT YOUR CLAIM

2) IF YOU ARE CLAIMING **PERSONAL INJURY CLAIM**, ALONG WITH THE COMPLETED FORM, PLEASE ENCLOSE THE FOLLOWING:
   a) INCIDENT REPORTS
   b) COPIES OF ITEMIZED BILLS FOR EACH MEDICAL EXPENSE INCURRED IN CONNECTION WITH YOUR CLAIM
   c) COPIES OF ALL MEDICAL RECORDS FROM ANY PROVIDERS IN CONNECTION WITH CLAIM SETTING FORTH THE NATURE AND EXTENT OF INJURY AND TREATMENT, ANY DEGREE OF TEMPORARY OR PERMANENT DISABILITY, THE PROGNOSIS, AND PERIOD OF HOSPITALIZATION,
   d) COPIES OF ALL INSURANCE POLICIES
   e) PHOTOGRAPHS, VIDEOS, OR ANY OTHER DOCUMENTATION TO SUPPORT YOUR CLAIM

3) IF YOU ARE MAKING A CLAIM FOR **LOST WAGES/INCOME**, ATTACH A LETTER FROM YOUR EMPLOYER VERYFYING YOUR LOST WAGES. IF SELF-EMPLOYED, A STATEMENT SHOWING THE CALCULATION OF YOUR CLAIMED LOST INCOME.

   PLEASE NOTE THAT IN ADDITION TO THE COMPLETED FORM AND THE ITEMS LISTED ABOVE, YOU MAY SUBMIT ANY OTHER DOCUMENTATION TO SUPPORT YOUR CLAIM.

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.

DATED: _____ **CLAIMANT:** _____