



# City of Lawrence

## Claim Form

### Risk Management Use Only

Event # \_\_\_\_\_

Claim # \_\_\_\_\_

Claim Type:

Property

Bodily Injury

Auto Property

Other

*This form must be completed by persons making a claim with the City of Lawrence. The term "event" refers to the circumstances you allege to be the cause of the injury or damages to your property.*

### PROCEDURES REQUIRED BY KANSAS STATUTE UNDER THE KANSAS TORT CLAIMS ACT

Claims for damages to or for loss or destruction of property or for personal injury against a city must be submitted in writing to the city

- A. (K.S.A. 12-105b).
- B. All items on this form must be completed. Insert the word "NONE" where applicable.
- C. Following receipt of this claim the City has up to 120 days to review it and make a determination.
- D. Your claim is deemed denied if no action is taken within 120 days following the filing of your claim.
- E. If you do not fully understand your rights and duties in making this claim, you should consult an attorney.
- F. Direct questions to the Risk Management Office, 6 E. 6th Street (785) 832-3010
- G. The acceptance or filing of this form does not constitute payment of your claim. The City will review it according to applicable law.

**Return this form to: Risk Management, City Hall, 6 E. 6th Street, Lawrence, KS 66044**

### CLAIMANT

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Event \_\_\_\_\_  
Time of Event \_\_\_\_\_ AM/PM  
Location of Event \_\_\_\_\_  
Name of City Employee(s) / Department Involved in Event (if known) \_\_\_\_\_  
\_\_\_\_\_

**BASIS OF CLAIM ALLEGATION:** (State below, in detail, all known facts and circumstances relating to the damage or injury to persons and property involved and the cause thereof. Attach an additional sheet if necessary.)

**NATURE AND EXTENT OF DAMAGE/INJURY ALLEGATION**

For property damage, do you own or lease the property? \_\_\_\_\_

For auto property damage, is the vehicle owned or leased? \_\_\_\_\_

Whose name appears on the title? \_\_\_\_\_

**MEDICAL PROVIDERS**

If medical treatment was sustained as a result of the incident, provide the names, addresses, phone numbers of physicians and medical staff

**WITNESSES**

Were there any witnesses to the event? If so, please list the witness's name, address, and phone number.

Name _____	Name _____
Address _____	Address _____
Phone _____	Phone _____

**INSURANCE COVERAGE**

Do you have insurance coverage? \_\_\_\_\_ Yes \_\_\_\_\_ No

Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Type of Coverage \_\_\_\_\_

Agent's name \_\_\_\_\_

Have you filed a claim with your insurance as a result of this incident? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, is it full coverage or deductible? \_\_\_\_\_ Full Coverage \_\_\_\_\_ Deductible \_\_\_\_\_

**CLAIMANT'S REPRESENTATIVE**

Have you authorized any other person besides yourself to act on your behalf in settling this claim? If yes, please fill out the following:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Relation to claimant \_\_\_\_\_

**AMOUNT OF CLAIM**

Property Damage or Loss	\$ _____	Attach itemized list and estimates
Auto Property Damage	\$ _____	Attach 3 estimates and a copy of the front and back of the title to the vehicle
Bodily Injury Expenses	\$ _____	Attach itemized invoices and medical records
<b>Total</b>	\$ _____	

I CERTIFY THAT THIS IS A TRUE AND ACCURATE STATEMENT OF THE EVENTS LEADING TO THIS CLAIM. I FURTHER CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE EVENT ABOVE.

Signature \_\_\_\_\_ Date \_\_\_\_\_