

## **INSTRUCTIONS FOR COMPLETING THE CLAIM FOR DAMAGE FORM**

Before filing a Claim for Damage please read these instructions and the Claim for Damage form in its entirety.

The Claim for Damage form must be signed and notarized. Type or print clearly in ink and sign the Claim for Damage form. If you are incapacitated, a minor or a non resident of the state, a relative, attorney or agent may sign on your behalf.

Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

The following are examples on how to complete the Claim for Damage form:

- (1) Doe, John Conner, 12/01/1910
- (2) 222 One Way Street, Apt. Z, Seattle, Washington 98178
- (3) Post Office Box 111, Seattle, Washington 98178
- (4) Same
- (5) (206) 555-5555
- (6) January 1, 2009, 8:00 a.m.
- (7) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item (7).
- (8) Washington, Thurston, Tumwater, parking lot of XYZ Cleaners.
- (9) I-5, southbound, Milepost, near Martin Way Exit.
- (10) Washington State Department of Transportation, highway
- (11) Fitzgerald III, Mortamer, 3287 Wonderful Lane, Seattle, Washington 98187, (360)111-1111; tow truck driver, XYZ Towing.
- (12) Unknown
- (13) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items (11) and (12). Also include a description of their knowledge. For example if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
- (14) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
- (15) If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
- (16) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include medical records and bills.
- (17) Attach documents which support the claim's allegations.
- (18) Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss etc. This amount should represent your opinion of total compensation.
- (19) If you were injured, please complete the Medicare Verification form.

**THE CLAIM FOR DAMAGE FORM MUST BE SIGNED AND NOTARIZED**

**CLAIM FOR DAMAGE FORM**

Under penalty of law, Enduris intends to prosecute all false claims.

**CLAIMANT INFORMATION**

(1) Claimant's Name: \_\_\_\_\_  
(Last Name) (First) (Middle) (Date of Birth: mm/dd/yyyy)

(2) Current Residential Address: \_\_\_\_\_

(3) Mailing Address (if different): \_\_\_\_\_

(4) Residential Address for Six Months Prior to the Date of the Incident (if different from current address):  
\_\_\_\_\_

(5) Claimant's Daytime Phone Numbers: Home Phone # \_\_\_\_\_, Business/Cell # \_\_\_\_\_  
Claimant's Email Address: \_\_\_\_\_

**INCIDENT INFORMATION**

(6) Date of Incident: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:

From: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)

To: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. (check one)  
(mm/dd/yyyy)

(8) Location of Incident: \_\_\_\_\_  
(state and county) (city if applicable) (place where occurred)

(9) If the incident occurred on a street or highway: \_\_\_\_\_  
(name of street/highway) (mile post) (at intersection with or  
nearest intersecting street)

(10) District or agency alleged responsible for damage/injury: \_\_\_\_\_

(11) Names, address, and telephone numbers of all persons involved in or witness to this incident:  
\_\_\_\_\_  
\_\_\_\_\_

(12) Name, addresses, and telephone numbers of all district or agency employee having knowledge about this incident:  
\_\_\_\_\_  
\_\_\_\_\_

(13) Names, addresses, and telephone numbers of all individuals not already identified in (11) and (12) above that have knowledge regarding the liability issues involved in this incident, or knowledge of the claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.  
\_\_\_\_\_  
\_\_\_\_\_

(14) Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(15) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

\_\_\_\_\_  
\_\_\_\_\_

(16) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

\_\_\_\_\_  
\_\_\_\_\_

(17) Please attach documents which support the claim's allegations.

(18) I claim damages in the amount of \$ \_\_\_\_\_

(19) If you are injured, are you a Medicare beneficiary?  Yes  No (check one) If Yes, please complete the Medicare Verification form.

**\*\*ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY\*\***

License Plate # \_\_\_\_\_ Driver License # \_\_\_\_\_

Type Auto: \_\_\_\_\_  
(year) (make) (model)

**DRIVER:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**OWNER:** \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**PASSENGERS:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

**NOTE: THIS FORM MUST BE SIGNED AND NOTARIZED**

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

x \_\_\_\_\_

x \_\_\_\_\_

Signature of Claimant(s)

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC in and for the State of Washington

**Submit the completed and notarized form to Kim Kawada at [kimk@portolympia.com](mailto:kimk@portolympia.com)  
or by mail to 915 Washington Street NE, Olympia, WA 98501.  
A confirmation receipt will be returned to the claimant.**