NOTICE OF TORT CLAIM

OKLAHOMA MUNICIPAL ASSURANCE GROUP (OMAG) – MUNICIPAL LIABILITY PROTECTION PLAN

A. CLAIMANT REPORT

To the _____

Public entity you are filing the claim against.

PLEASE PRINT OR TYPE AND SIGN

IMPORTANT NOTICE: This notice will be sent to OMAG Claims Dept. for investigation. You may expect them to contact you.

CLAIMANT(S)_____ CLAIMANT(S) SOCIAL SECURITY NO._____

ADDRESS_____ CLAIMANT(S) DATE OF BIRTH _____ Circle: M F

_____ PHONE: HOME (___)_____ _____ BUS. (___)_____

(Exact Date Required) **(Continue on another sheet if needed for any information requested)**

1. DATE AND TIME OF INCIDENT _____(___) a.m. (___) p.m.
2. LOCATION OF INCIDENT_____
3. DESCRIBE INCIDENT _____

_____

_____

4. LIST ALL PERSONS AND/OR PROPERTY FOR WHICH YOU ARE CLAIMING DAMAGES:

BODILY INJURY: WAS CLAIMANT INJURED? YES___ NO___ If yes, complete this section

Describe injury _____

WERE YOU ON THE JOB AT THE TIME OF INJURY? YES___ NO___ If so, please provide Employer info.

_____

Employer's Name Address Phone

ALL MEDICAL BILLS (attach copies) $_____

LIST OTHER DAMAGES CLAIMED $_____

MEDICARE/MEDICAID/SOCIAL SECURITY DISABILITY:

Is there any Social Security Disability involvement ___Yes ___ No

Has any medical bill been paid or will be paid by Medicare/Medicaid? ___Yes ___No. If so, list Medicare/Medicaid Number.

Medicare/Medicaid Number _____

If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y.

_____ _____

Medicare/Medicaid Beneficiary Name (please print) Medicare/Medicaid Beneficiary Name Signature

PROPERTY DAMAGE: Proof that you are the owner of the vehicle or property allegedly damaged as specified in your claim will be required.

VEHICLE YEAR_____ MAKE _____ MODEL_____

NOTE: <u>If damage is to a vehicle, a photocopy of your motor vehicle title is required.</u>

IF NOT A VEHICLE, DESCRIBE PROPERTY AND LOSS_____

_____

PROPERTY DAMAGE (Attach repair bills or estimates if available) $_____

LIST OTHER DAMAGES CLAIMED $_____

5. NAME OF YOUR INSURANCE CO.	POLICY NO.	AMOUNT CLAIMED	AMOUNT RECEIVED
_____	_____	$_____	$_____

6. The names of any witnesses known to you:

_____

Name Address Phone Number

_____

Name Address Phone Number

STATE THE EXACT AMOUNT OF COMPENSATION YOU WOULD ACCEPT AS FULL SETTLEMENT ON THIS CLAIM.

TOTAL CLAIM..... $_____

_____

SIGNATURE(S) DATE

CONTINUE ON THE BACK

B. THIS SECTION IS FOR USE BY THE PUBLIC ENTITY WHICH RECEIVES THE CLAIM

To inquire about this claim you may write to OMAG Claims Dept. or call 1-800-234-9461; or in Edmond call 657-1400

This Notice of Tort Claim was received by _____

(Title)_____, on_____, 20____

For further information on this claim contact_____

(Title)_____, by telephone at (_____)_____

The following reports, statements or other documentation, which support our understanding of the facts relating t claim, are attached:

_____

_____

_____

_____

Persons who have knowledge of the circumstances surrounding this claim are:

	Name	Title/Position	Telephone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Submitted by:_____Date_____, 20____

Title:_____

AFTER THE PUBLIC ENTITY HAS RECEIVED THIS CLAIM, PLEASE PROVIDE INFORMATION REQUESTED ABOVE AND IMMEDIATELY SEND TO:

OMAG Claims Dept.
3650 S. Boulevard
Edmond, OK 73013-5581
Fax (405) 657-1401