



BOROUGH OF BOUND BROOK

NOTICE OF CLAIM

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF
ACCIDENT/OCCURRENCE OR YOU MAY FORFEIT YOUR RIGHTS PURSUANT
TO N.J.S.A. 59:1 ET SEQ.

FORWARD TO: Clerk's Office
Borough of Bound Brook
230 Hamilton Street
Bound Brook, New Jersey 08805

CLAIMANT: (LAST, FIRST, MIDDLE)		FULL ADDRESS:	
DATE OF BIRTH:	SSN:	TELEPHONE:	
2. IF NOTICE AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, PLEASE COMPLETE ITEM #2:			
NAME: (LAST, FIRST, MIDDLE)		DATE OF BIRTH:	SSN:
FULL STREET ADDRESS:		TELEPHONE:	
3. A. AT THE OCCURRENCE OR ACCIDENT WHICH GAVE RISE TO THIS CLAIM:			
DATE:		TIME:	
B. DESCRIBE THE LOCATION OR PLACE OF THE ACCIDENT OR OCCURRENCE:			
MUNICIPALITY:		EXACT LOCATION:	
C. DESCRIBE HOW THE ACCIDENT OR OCCURRENCE HAPPENED. IF A DIAGRAM WILL ASSIST YOUR EXPLANATION, PLEASE USE THE REVERSE SIDE OF THIS FORM:			
D. STATE THE NAME ADDRESS OF THE MUNICIPALITY OR AGENCY THAT YOU CAN CLAIM CAUSED YOUR DAMAGE:			

E. STATE THE NAMES OF MUNICIPALITY'S EMPLOYEES WHOM YOU CAN CLAIM WERE AT FAULT. INCLUDING ANY INFORMATION THAT WILL ASSIST IN IDENTIFYING THEM:

F. STATE IN DETAIL EACH AND EVERY NEGLIGENT OR WRONGFUL ACT OF THE MUNICIPALITY EMPLOYEES WHICH CAUSED YOUR DAMAGE:

G. STATE THE NAME AND ADDRESS OF ALL WITNESS TO THE ACCIDENT OR OCCURRENCE:

H. IF VEHICLE ACCIDENT, STATE THE NAMES, ADDRESS, AGE AND RELATIONSHIP TO INSURED OF ALL PASSENGERS IN YOUR VEHICLE:

I. STATE THE NAMES OF ALL POLICE OFFICERS AND POLICE DEPARTMENTS WHO INVESTIGATED THE ACCIDENT:

4. A. CLAIM FOR DAMAGES (CHECK APPROPRIATE BOX):

☐ BODILY INJURY ☐ PROPERTY DAMAGE ☐ OTHER EXPLAIN

B. 1. IF YOU CLAIM INJURY, DESCRIBE YOUR INJURIES RESULTING FROM THIS ACCIDENT OR OCCURRENCE:			
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 SERVICE, STATE:			
NAME & ADDRESS OF HOSPITAL, DOCTOR, OR OTHER FACILITY	DATES OF TREATMENT	AMOUNT OF CHARGE TO DATE	AMOUNT PAID OR PAYABLE BY OTHER INSURANCE
A)			
B)			
C)			
D)			
4. IF YOU CLAIM LOSS OF WAGES OR INCOME AS A RESULT OF THE INJURY, STATE:			
NAME OF EMPLOYER:		ADDRESS:	
YOUR OCCUPATION:		DATE EMPLOYED AT THIS JOB:	
RATE OF PAY:		DATES OF ABSENCES FROM WORK:	
NOTE: IF YOU CLAIMED LOSS OF INCOME ARISES FROM SELF-EMPLOYMENT OR OTHER THEN WAGE, ATTACH A CALCULATION ON THE BASIS OF YOUR CALCULATION OF LOSS INCOME.			
5. SET FORTH ANY AND ALL OTHER LOSSES OR DAMAGES CLAIMED BY YOU:			
C) IF YOU CLAIM PROPERTY DAMAGE:			
1) DESCRIBE THE PROPERTY DAMAGED, IF VEHICLE:			
MAKE	MODEL	YEAR	COLOR

VEHICLE IDENTIFICATION #	LICENSE PLATE #	STATE
PARTS OF VEHICLE DAMAGED: 		
2) THE PRESENT LOCATION AND TIME THE PROPERTY CAN BE INSPECTED 		
3) DATE PROPERTY ACQUIRED:	4) COST OF PROPERTY:	5) VALUE OF PROPERTY AT TIME OF ACCIDENT
6) DESCRIPTION OF DAMAGE: 		
7) HAS THE DAMAGE BEEN REPAIRED? ☐ YES ☐ NO IF YES, BY WHOME, AND COST OF REPAIRS: 		
8) ATTACH EACH ESTIMATE OF REPAIR COST TO THIS FORM.		
9) SET FORTH IN DETAIL THE LOSS CLAIM BY YOU FOR PROPERTY DAMAGE: 		
D) SET FORTH IN DETAIL ALL OTHER ITEMS OF LOSS OR DAMAGES CLAIMED BY YOU AND THE METHOD BY WHICH YOU MADE THE CALCULATIONS: 		
5. THE AMOUNT OF CLAIM:		
7. ARE ANY OF THE LOSSES OR EXPENSES CLAIMED HEREIN COVERED BY ANY POLICY OF INSURANCE? ☐ YES ☐ NO FOR EACH SUCH POLICY, STATE THE NAME AND ADDRESS OF THE INSURANCE COMPANY, POLICY NUMBER AND BENEFITS PAID OR PAYABLE: 		

8. HAVE YOU RECEIVED OR AGREE TO RECEIVE ANY MONEY FROM ANYONE FOR DAMAGES CLAIMED HEREIN?

☐ YES ☐ NO

IF YES, SET FORTH THE DETAILS OF SUCH AGREEMENT:

9. THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE:

1. COPIES OF ITEMIZED BILLS FOR EACH MEDICAL EXPENSE AND OTHER LOSSES AND EXPENSES CLAIMED.
2. FULL COPIES OF ALL APPRAISALS AND ESTIMATES OF PROPERTY DAMAGE CLAIMED BY YOU.
3. COPIES OF ALL WRITTEN REPORTS OF ALL EXPERT WITNESSES AND TREATING PHYSICIANS.
4. A LETTER FROM YOUR EMPLOYER VERIFYING YOUR LOST WAGES. IF SELF EMPLOYED A STATEMENT SHOWING CALCULATIONS OF YOUR 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 ONE KNOWN TO ME TO BE IN EXISTENCE AT THIS TIME. I AM AWARE THAT IF ANY STATEMENT MADE HEREIN IS WILLFULLY FALSE OR FRAUDULENT, I AM SUBJECT TO PUNISHMENT AS PROVIDED BY LAW.

DATE: _____

CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

PRINT NAME AS SIGNED ABOVE

**HIPPA COMPLAINT AUTHORIZATION
TO DISCLOSE HEALTH INFORMATION**

Please provide an authorization for each medical provider

Patient Name:	Address:
SSN#:	DOB:

I hereby authorize the below listed physician/medical provider/hospital to release **ANY AND ALL RECORDS IN THEIR POSSESSION PERTAINING TO ME**, included but not limited to, medical office, and/or treatment records; office notes, treatment examination and/or consultation reports, diagnostic test results, X-ray, MRI and CT Films and Reports from: **The Past (5) years**.

Provider Name _____ Address _____

This information may be disclosed to:

**The Middlesex County Municipal Joint Insurance Fund Claims Department and/or its Representatives
2 Jocama Boulevard
Old Bridge, New Jersey 08857**

For the purpose of: **I am a claimant in a personal injury matter.**

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy office of the above name facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire on the following date: **6 months**

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information. I may contact the privacy officer at the facility listed above that is authorized to disclose this information.

I understand that my health records may include information pertaining to treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. If you do not wish this information to be released **please initial;** **DO NOT RELEASE** _____

Signature of Patient or Authorized Representative

Date

Description of Representative's Authority
(Witness signature required)

Signature of Witness

AUTHORIZATION FOR INFORMATION ON EMPLOYMENT

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE MIDDLESEX COUNTY MUNICIPAL JOINT INSURANCE FUND CLAIMS DEPARTMENT OR ITS REPRESENTATIVES ANY AND ALL MEDICAL INFORMATION CONCERNING MY EMPLOYMENT, PAST OR PRESENT, INCLUDING RATE OF PAY, DUTIES TO BE PERFORMED, DATES OF ABSENCES AND REASONS THEREFORE.

A PHOTOCOPY OF THIS DOCUMENT WILL BE ACCEPTABLE AS AN ORIGINAL

DATED: _____

SIGNATURE

PRINT NAME AS SIGNED ABOVE