

LIABILITY CLAIM / INCIDENT REPORT

Note: Use this form to report: 1) any claim which caused bodily injury or property damage to a claimant, or 2) any incident that has potential to cause bodily injury or property damage to a claimant, or 3) any claim that falls within the Types of Claim listed below in box 9.

The following instructions are to assist in the completion of the Liability Claim/Incident Report:

1. **Name of Member:** *Municipality Name*, NOT the person completing form or claimant or department involved in claim / incident.
2. **Department:** Means *the department involved in claim / incident*, NOT the name of department completing the form.
3. **Phone Number:** Means *telephone number of the department involved in the accident*, NOT the person or department completing the form.
4. **Reported By:** Means individual reporting the claim / incident to the Member contact or other person who completed the form.
5. **Exact Location:** Street address where the claim / incident occurred. It is ok to use a common name like DPW Building.
6. **Date of Claim/Incident:** Date when the claim / incident occurred.
7. **Time:** Time of day when the claim / incident occurred.
8. **Date Reported:** The date that the Member was first advised by claimant or sub-department that a claim / incident occurred.
9. **Type of Claim:** Check the liability type of claim that is being reported. This list is not an exhaustive list, but rather a list of the more frequent types of claims that are reported. **If none of the claim types match what is being reported, it is ok to leave blank.**
10. **Claimant Contact Information:** List name and contact information for person claiming injury or damages. If claimant is a minor (under age of 18), include name of parent(s) or guardian(s).
11. **Claimant Age:** Provide claimant's age and date of birth.

12. **Describe Injury:** Provide description of injury. Examples: strain or sprain, contusion or laceration, bruise, fracture, death, etc.
13. **Body Part Injured:** Provide the part of body that was injured. Example: head, left or right arm, left or right leg, neck, back, knee, foot, etc.
14. **Claimant's Employer:** Name of place where claimant works, if known.
15. **Claimant Occupation:** What is claimant's job title or type of work performed?
16. **Did Claimant Lose Work Time:** Due to injury, did claimant lose time from work?
17. **Claimant's Social Security #:** We ask for claimant's social security number so that we can verify if claimant is Medicare / Medicaid eligible.
18. **Describe Property Damage:** Describe what was damaged.
19. **Cause of Damage:** Describe what caused the property damage.
20. **Extent of Damage:** Describe damage, example: scratch, blown tire, total loss, etc.
21. **Estimate Cost to Repair:** List dollar amount of repair estimate. MMRMA generally request 2 estimates for repair. Please attach a copy of estimates.
22. **Actual Cost to Repair:** Provide copy of repair invoice, if repair is already complete.
23. **Witness Names / Addresses:** List witness name(s) and contact information for those who saw or have knowledge of how the damage occurred.
24. **Photographs Taken:** Indicate whether or not photographs were taken and whether or not you have attached the photographs. If at all possible, please try to get photos of the scene of any accident. The sooner the pictures are taken, the more valuable they become because the photos more accurately show the conditions at the time the claim / incident happened.
25. **Supporting Documents:** Indicate whether you have any supporting documents as to how the loss occurred or to substantiate the amount of the loss, and whether or not you have attached the supporting documents.

- 26. Police Report:** If the loss was reported to the police, provide the police report number and indicate whether or not you have attached the police report.
- 27. Describe What Happened:** Provide detailed, written description of how the claim / incident occurred. Factual statements, rather than opinions, are preferred when completing this claim form.
- 28. Lawsuit:** Please complete sections A, B, C and D and attach lawsuit to claim form, then submit to MMRMA Claims Office.
- 29. Submitted By:** Name of individual person completing form (generally we ask that the MMRMA Member Representative complete the form).
- 30. Title:** Provide the title of the person completing this form.
- 31. Date:** The date person identified in (29) filled out claim form.



LIABILITY CLAIM / INCIDENT REPORT

*Use this form to report: 1) any claim which caused bodily injury or property damage to a Claimant or 2) any incident that has potential to cause bodily injury or property damage to a Claimant.

(1) Name of MMRMA Member:	(2) Member Department:	(3) Member Department Phone #:	(4) Reported By:
(5) Exact Location of Claim/Incident:	(6) Date of Claim/Incident:	(7) Time of Incident: A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	(8) Date Reported By Department:

(9) **TYPE OF CLAIM:**

Bodily Injury Civil Rights Complaint Open Meetings Act Zoning Dispute Personal Injury
 Property Damage EEOC/MDCR Complaint Freedom of Information Act Land Use Dispute Data Breach / Cyber

Claim Notice Only

CLAIMANT INFORMATION

(10) Claimant's Name: Name of Parent or Guardian (if applicable):	Claimant's Address:	Claimant's Telephone #: Cell #: Home #: Work #:
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BODILY INJURY INFORMATION

PROPERTY DAMAGE INFORMATION

(11) Claimant's Age:	Date of Birth:	(18) Describe Property Damaged:	
(12) Describe Injury:		(19) Cause of Damage:	
(13) Part of Body Injured:		(20) Extent of Damage:	
(14) Claimant's Employer:	(15) Claimant's Occupation:	(21) Estimated Cost to Repair: \$	(22) Actual Cost to Repair: \$
(16) Did Claimant Lose Work Time? Yes <input type="checkbox"/> No <input type="checkbox"/>	(17) Claimant Social Security #:		

(23) Name of Witness:	Witness Address:	Witness Telephone #:
1)		
2)		
3)		
(24) Photographs Taken? Yes <input type="checkbox"/> No <input type="checkbox"/> Photographs Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	(25) Other Supporting Documents? Yes <input type="checkbox"/> No <input type="checkbox"/> Supporting Documents Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>	(26) Police Report #: Police Report Attached? Yes <input type="checkbox"/> No <input type="checkbox"/>

(27) Please describe in detail how the claim/incident occurred (attach any supporting data):

(28) LAWSUIT	D. Please List Employees / Officials of Member who are Identified on the Complaint:	
A. Date of Service:	1)	6)
B. Method of Service: <input type="checkbox"/> In Person <input type="checkbox"/> Mail	2)	7)
C. Name of Person Served and Title:	3)	8)
	4)	9)
	5)	10)

(29) Submitted by:	(30) Title:	(31) Date:
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