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.

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 XYZ Exit.
- (10) XYZ Barone Sanitation
- (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 (attached).

		Addres	is	
District Business Hours				
business nours				
	CLAIM	FOR DAMAGE	E FORM	
Under	penalty of law, En	nduris intends to p	orosecute all false	claims.
CLAIMANT INFORMATION				
(1) Claimant's Name:				
(Las	t Name)	(First)	(Middle)	(Date of Birth: mm/dd/yyyy
(2) Current Residential Address:				
3) Mailing Address (if different):				
(4) Residential Address for Six Months F	Prior to the Date o	of the Incident (if o	different from cur	rent address):
,		`		,
5) Claimant's Daytime Phone Numbers Claimant's Email Address:			, Dusiness/Ci	z11 #
INCIDENT INFORMATION				
INCIDENT INFORMATION (6) Date of Incident:(mm/dd/yyyy)	Time:		.m. □p.m. (che	ck one)
(6) Date of Incident:(mm/dd/yyyy) (7) If the incident occurred over a perio	od of time, date of	first and last occu	ırrences:	ck one)
(6) Date of Incident: (mm/dd/yyyy) (7) If the incident occurred over a perio From: Time:	od of time, date of	first and last occu a.m. p p.m. (che	urrences: eck one)	ck one)
(6) Date of Incident: (mm/dd/yyyy) (7) If the incident occurred over a perio From: Time:	od of time, date of	first and last occu a.m. p p.m. (che	urrences: eck one)	ck one)
(6) Date of Incident:(mm/dd/yyyy) (7) If the incident occurred over a perior From: Time: (mm/dd/yyyy) To: Time: (mm/dd/yyyy)	od of time, date of	first and last occu a.m. p p.m. (che	urrences: eck one)	ck one)
(6) Date of Incident:(mm/dd/yyyy) (7) If the incident occurred over a perior From: Time: (mm/dd/yyyy) To: Time: (mm/dd/yyyy)	od of time, date of	first and last occu a.m. p p.m. (che	urrences: eck one)	
(6) Date of Incident: (mm/dd/yyyy) (7) If the incident occurred over a periofone: Time: Time: Time: Time: (mm/dd/yyyy) To: Time: (mm/dd/yyyy) (8) Location of Incident: (state and courted)	od of time, date of a a a	first and last occu a.m. □p.m. (che a.m. □p.m. (che	urrences: eck one) eck one)	
(6) Date of Incident:(mm/dd/yyyy) (7) If the incident occurred over a perio From: Time:	od of time, date of a a nty) (city or highway:	first and last occu a.m. □p.m. (che a.m. □p.m. (che	urrences: eck one) eck one) (place where	e occurred) (at intersection with or
(6) Date of Incident:(mm/dd/yyyy) (7) If the incident occurred over a perion From: Time: (mm/dd/yyyy) To: Time: (mm/dd/yyyy) (8) Location of Incident: (state and cour	od of time, date of late lat	first and last occu a.m. □p.m. (che a.m. □p.m. (che rif applicable) ne of street/highv	urrences: eck one) eck one) (place where way) (mile post	e occurred) (at intersection with or
(6) Date of Incident: (mm/dd/yyyy) (7) If the incident occurred over a perio From: Time: Time: To: Time: Time: (mm/dd/yyyy) (8) Location of Incident: (state and cour	od of time, date of late lat	first and last occu a.m. p.m. (che a.m. p.m. (che if applicable) ne of street/highv	urrences: eck one) eck one) (place where way) (mile post	e occurred) (at intersection with or nearest intersecting stree

(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.

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(15) Has this in	cident been reported to law en	forcement, safety or	security persor	nnel? If so, when and to whom?	
(16) Names, ad	dresses and telephone number	rs of treating medica	l providers. Att	tach copies of all medical reports and billi	ngs.
(17) Please atta	ach documents which support t	he claim's allegation	ıs.		
(18) I claim dan	mages in the amount of \$				
(19) If you are i form.	njured, are you a Medicare ben	eficiary? □Yes □N	lo (check one)	If Yes, please complete the Medicare Ver	rification
	ADDITIONAL	INFORMATION REQUIRE	D FOR AUTOMOE	BILE CLAIMS ONLY	
License Plate #	F		Oriver License #	#	
Type Auto:					
71	(year)	(mal	ke)	(model)	
DRIVER:			OWNER:		
Address:			Address:		
Phone #:			Phone #:		
PASSENGERS: Name: Address:			Name: Address:		
may be signed I declare under	on behalf of the claimant by ar	ny relative, attorney, nws of the state of Wa	or agent repres	the foregoing is true and correct.	
I, that I have read	the above claim, know the co	eing first duly sworn ntents thereof and b	, depose and selieve the same	ay that I am the claimant for the above de e to be true.	escribed;
			x _		
			x	Signature of Cla	
			_	Signature of Cla	imant(s)
Subscribed and	d sworn to before me this	day of	, 2	20	
NOTARY PUBLIC ir	n and for the State of Washingto	on			

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

SIL MEDICARE TIER	ALTH INSURANCE
JOHN L SMITH	
Medicare Number Numero de Medicare 1EG4-TE5-MK72	
HOSPITAL (PART A) MEDICAL (PART B)	03-01-2016 03-01-2016

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?							□ Yes			□ No						
If yes, please complete the following. If no, proceed to Section II.							100									
Full Name: (Please print the name exactly as it appears on	your	rSSA	l or	Med	icare	card	if av	aila	ble.)							
	П															
	\perp															
Medicare Number:		11			Date of Birth /					1						
					(M	o/Day	y/Ye	аг)								
**Social Security Number:			•		-				Sex	В	Fem	ale			Mal	е
(If Medicare Number is Unavailable)											_					

^{**} Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II	
I understand that the information requested is to assist the requebenefits with Medicare and to meet its mandatory reporting oblig	
Claimant Name (Please Print)	Medicare Number
Name of Person Completing This Form If Claimant is Unable	e (Please Print)
Signature of Person Completing This Form	Date
If you have completed Sections I and II above, stop here. If you sections I and II, proceed to Section III.	are refusing to provide the information requested in
Section III	
Claimant Name (Please Print)	Medicare Number
For the reason(s) listed below, I have not provided the information beneficiary and I do not provide the requested information, I may in coordinating benefits to pay my claims correctly and promptly.	y be violating obligations as a beneficiary to assist Medicare
Reason(s) for Refusal to Provide Requested Information:	
	·

Date

Signature of Person Completing This Form