

CITY OF PHILADELPHIA
RISK MANAGEMENT DIVISION - CLAIMS UNIT
1515 ARCH STREET - 14th FLOOR
PHILADELPHIA, PA 19102
PHONE (215) 683-1700

GENERAL CLAIM INFORMATION FORM

NAME: _____ TODAY'S DATE: _____

ADDRESS: _____ HOME TELEPHONE NUMBER: _____

_____ WORK TELEPHONE NUMBER: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

DATE AND TIME OF THE ACCIDENT/INCIDENT: _____

SPECIFIC LOSS LOCATION: _____

DESCRIPTION OF THE LOSS EVENTS BEING PRESENTED AGAINST THE CITY (IN DETAIL):
(PLEASE USE REVERSE SIDE OR ADDITIONAL SHEET OF PAPER IF MORE ROOM IS NEEDED)

VERIFICATION THAT THE POLICE WERE NOTIFIED OF THE LOSS: _____ YES _____ NO

PLEASE PROVIDE THE POLICE REPORT DISTRICT CONTROL NUMBER: _____

NAME OF THE CITY DEPARTMENT INVOLVED: _____

NAME OF THE CITY EMPLOYEE INVOLVED: _____

CITY VEHICLE NUMBER OR TAG NUMBER: _____

NAMES OF ANY KNOWN WITNESS (ES): _____

ADDRESS AND/OR PHONE NUMBER OF THE WITNESS (ES): _____

IN ADDITION TO COMPLETING THIS FORM, PLEASE PROVIDE THIS OFFICE WITH THE FOLLOWING INFORMATION:

- A COPY OF YOUR INSURANCE DECLARATION SHEET. IF YOU HAVE NO INSURANCE PLEASE INDICATE THAT IN THE LOSS DESCRIPTION. THE CITY WILL PROVIDE AN AFFIDAVIT OF NO INSURANCE TO BE NOTARIZED AFTER SUBMITTING THIS LOSS.
- TWO WRITTEN ESTIMATES FOR THE REPAIR/REPLACEMENT OF YOUR PROPERTY.
- PHOTOGRAPHS OF THE DEFECTIVE CONDITION CAUSING THE LOSS AND YOUR DAMAGED PROPERTY.
- PROVIDE A COPY OF VEHICLE REGISTRATION.
- **NOTE: ALL DOCUMENTATION SUBMITTED WITH THIS FORM BECOMES PROPERTY OF THE CITY OF PHILADELPHIA, AND ARE NON-RETURNABLE.**

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, MUNICIPALITY OR ANY OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____

BODILY INJURY CLAIM FORM ATTACHMENT

CLAIMANT INFORMATION

DID YOU RECEIVE EMERGENCY MEDICAL TREATMENT? _____ YES _____ NO

IF YES, WHERE WERE YOU TREATED: _____

WERE YOU PROVIDED MEDICAL TRANSPORT: _____ YES _____ NO

WERE YOU HOSPITALIZED AS A RESULT OF THIS LOSS: _____ YES _____ NO

IF YES, WHERE WERE YOU HOSPITALIZED: _____

HOW LONG WERE YOU HOSPITALIZED: _____

PLEASE PROVIDE THE NAME AND ADDRESS OF YOUR TREATING PHYSICIAN:

PLEASE DESCRIBE THE INJURY (IES) FOR WHICH YOU WERE TREATED:

WAS FOLLOW UP TREATMENT RECOMMENDED? _____

IF YES, PLEASE DESCRIBE: _____

PLEASE PROVIDE THE TOTAL DURATION OF YOUR TREATMENT

DATE STARTED: _____

DISCHARGE DATE: _____

(IF TREATMENT IS ON GOING, PLEASE INDICATE)

IN ADDITION TO COMPLETING THIS FORM, PLEASE PROVIDE THIS OFFICE WITH THE FOLLOWING INFORMATION:

- INFORMATION REGARDING YOUR INSURANCE COVERAGE (AUTOMOBILE, HEALTH INSURANCE OR ANY OTHER AVAILABLE COVERAGE). IF YOU HAVE NO INSURANCE PLEASE INDICATE THAT IN THE LOSS DESCRIPTION. THE CITY WILL PROVIDE AN AFFIDAVIT OF NO INSURANCE TO BE NOTARIZED AFTER SUBMITTING THIS LOSS.
- COPIES OF ALL MEDICAL REPORTS, MEDICAL BILLS AND DOCTOR'S NARRATIVES.
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SIGNATURE: _____ DATE: _____