

CITY OF PHILADELPHIA  
RISK MANAGEMENT DIVISION - CLAIMS UNIT  
1515 ARCH STREET - 14<sup>th</sup> 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: \_\_\_\_\_