CITY OF PHILADELPHIA
OFFICE OF THE DIRECTOR OF FINANCE
Risk Management Division
Claims Unit

1515 Arch Street, 14th Floor
One Parkway Building
Philadelphia, PA. 19102 –1579
Phone: (215)-683-1713

Dear Claimant:

Enclosed please find a claim form for you to complete and return to us. Please note this is a General Claim Form for Bodily Injury, Auto and Property. Please complete those sections that apply to your claim and disregard anything that does not apply. **Date of Birth and Social Security Number** must be completed for all claims.

If you are making a claim for property damage and you are covered under a homeowners' liability insurance policy or automobile liability insurance policy, you must notify your primary insurance company of an occurrence. According to the Governmental Immunity Tort Act, recovery on a claim against the City of Philadelphia is limited to the amount of an uninsured loss where The City of Philadelphia holds liability. The Governmental Immunity Tort Act does not permit an insurance company to bring a subrogation action against The City of Philadelphia.

Please make sure you advise us of the city department you are making the claim against (Police, Fire, Prisons, Streets, Water, License and Inspection etc). This information can be placed in the Name of City Department Involved section of the form.

If you are making a bodily injury claim and are receiving Medicare or Medicaid, please state your benefit number under your signature.

Be advised that under the Governmental Immunity Tort Act, the City of Philadelphia must have written notice of your claim within six months of the date of loss. Further, the statute of limitation in the state of Pennsylvania is two years from the date of loss, which means your claim must be filed within two years or you are barred from recovery. Please note that the statute of limitation in the state of Pennsylvania for minors is two years from the date of their eighteenth birthday. To extend the statute you must file a Cause of Action within the two-year period.

Once we receive your General Claim Information Form, your case will be assigned to an adjuster who will contact you by mail. The turnaround time depends on our volume. All documents requested on the form must be sent to us with your completed claims form.

Sincerely,

City of Philadelphia/Risk Management Division/Claims Unit

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 PENALITIES.

CITY OF PHILADELPHIA

RISK MANAGEMENT DIVISION - CLAIMS UNIT
1515 ARCH STREET – 14th FLOOR
PHILADELPHIA, PA 19102-1595
(215) 683-1713

GENERAL CLAIM INFORMATION FORM

NAME:_____ DATE:_____

ADDRESS:_____ HOME PHONE NUMBER:_____

_____ CELL PHONE NUMBER:_____

CITY/STATE/ZIP: _____ WORK PHONE NUMBER:_____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER:_____

(Must provide date of birth and social security number in order for claim to be processed)

DATE AND TIME OF THE ACCIDENT/INCIDENT:_____

SPECIFIC LOSS LOCATION:_____

DESCRIPTION OF THE ACCIDENT/INCIDENT:_____

_____

_____

WERE THE POLICE 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 PROPERTY NUMBER OR TAG NUMBER:_____
NAME(S), ADDRESS(ES) AND/OR PHONE NUMBER(S) OF ANY KNOWN WITNESS (ES):_____

_____

_____

_____

_____

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

- A COPY OF YOUR VEHICLE REGISTRATION **COVERING THE DATE OF THE ACCIDENT/INCIDENT.**
- A COPY OF YOUR INSURANCE DECLARATION SHEET **COVERING THE DATE OF THE ACCIDENT/INCIDENT**.
- **TWO** WRITTEN ESTIMATES ITEMIZING PART(S), PRICE, AND LABOR.
- PHOTOGRAPHS OF YOUR DAMAGED PROPERTY.
- PHOTOGRAPHS OF THE DEFECTIVE CONDITION THAT CAUSED THE LOSS (I.E., POTHOLE, TREE, ETC.).

NOTE: ALL DOCUMENTATION SUBMITTED WITH THIS FORM BECOMES PROPERTY OF THE CITY OF PHILADELPHIA AND ARE NON-RETURNABLE.

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SIGNATURE:_____

E-MAIL:_____

BODILY INJURY CLAIM FORM ATTACHMENT

CLAIMANT INFORMATION

DID YOU RECEIVE EMERGENCY MEDICAL TREATMENT? _____YES _____NO
IF YES, WHERE WERE YOUR 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(S):

_____

_____

_____

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
START DATE:_____
DISCHARGE DATE: _____

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

- INFORMATION REGARDNG YOUR INSURANCE COVERAGE (AUTOMOBILE, HEALTH, OR ANY OTHER AVAILABLE COVERAGE) **COVERING THE DATE OF THE ACCIDENT/INCIDENT.**
- PLEASE PROVIDE YOUR MEDICAID/MEDICARE MEMBER ID NUMBER:_____
- COPIES OF ALL MEDICAL RECORDS AND MEDICAL BILLS.

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SIGNATURE: _____DATE:_____