

## **NOTICE OF TORT CLAIM**

**GENERAL INSTRUCTIONS:** Pursuant to the provisions of the New Jersey Tort Claims Act, this Notice of Tort Claim form has been adopted as the official form for the filing of claims against the City of Atlantic City.

The questions are to be answered to the extent of all information available to the Claimant or to his or her attorneys, agents, servants, and employees, under oath. The fully completed Claim Form and the documents requested shall be returned to:

**Atlantic City City Hall  
City Clerk's Office, Room 704  
1301 Bacharach Blvd.  
Atlantic City, New Jersey 08401**

**NOTE CAREFULLY:** Your claim will not be considered filed as required by the New Jersey Tort Claims Act until this completed form has been filed with the City Clerk of Atlantic City. Failure to provide the information requested, including such responses as "To Be Provided" or "Under Investigation" will result in the claim being treated as not being properly filed.

Timely Notice of Claim must be filed within 90 days after the incident giving rise to the claim.

This form is designed as a general form for use with respect to all claims. Some of the questions may not be applicable to your particular claim. For example, if your claim does not arise out of an automobile accident, questions regarding road conditions might not be applicable. In that event, please indicate "Not Applicable".

If you are unable to answer any question because of a lack of information available to you, specify the reason the information is not available to you. If a question asks that you identify a document, it will be sufficient to furnish true and legible copy. Where a question asks that you "identify all persons," provide the name, address and telephone number of the person.

If you need more space to provide a full answer, attach supplementary pages, identifying the continuation of the answer with the number to the applicable question.

**1. CLAIMANT INFORMATION:**

\_\_\_\_\_  
**Last Name, First, Middle**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**Mailing Address If Other  
Than Street Address**

\_\_\_\_\_  
**City, State, Zip Code**

\_\_\_\_\_  
**Social Security #**

\_\_\_\_\_  
**Telephone #**

**If notices and correspondence in connection with this claim are to be sent to a person other than the claimant, complete Item #2.**

**2.**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Mailing Address**

\_\_\_\_\_  
**City, State, Zip Code**

**Relationship to claimant: Attorney At Law ( ) or \_\_\_\_\_**  
**Explain Relationship**

**The occurrence or accident which gave rise to this claim:**

**3a.** \_\_\_\_\_  
**Date** **Time**

**b. Describe the location or place of the accident or occurrence.**

\_\_\_\_\_  
**Municipality**

\_\_\_\_\_  
**Exact Location of the Occurrence**

**c. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**d. State the name and address of the Public Entity, or entities, that you claim caused your damage.**

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**State the names of the employees whom you claim were at fault, including any information that will assist in identifying and locating them.**

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**e. State, in detail, the negligence or wrongful acts of the Public Entity and public employees which caused your damages.**

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**f. State the name and address of all witnesses to the accident or occurrence.**

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**g. State the names of all police officers and police departments who investigated the accident.**

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**4a. Claim for Damages (Check appropriate block.)**

- Personal Injury**                       **Property Damage**  
 **Other – Explain in Detail** \_\_\_\_\_

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**b. If you claim personal injury:**

**(1) Describe your injuries resulting from this accident/occurrence.**

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**(2) Do you claim permanent disability resulting from this injury?  
If yes, describe the injuries believed to be permanent.**

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**(3) For each hospital, doctor, or other practitioner rendering treatment, examination or diagnostic services, state:**

<b>Name of hospital, Doctor, or other Address Facility</b>	<b>Dates of treatment or service</b>	<b>Amt. of charges to date</b>	<b>Amt. Paid or payable by other sources such as</b>

**Provide copies of all written reports of your attending physicians or dentists setting forth the nature and extent of injury and treatment, any degree of temporary or permanent disability, the prognosis, period of hospitalization, and any diminished earning capacity.**

**Provide copies of itemized bills for medical, dental, and hospital expenses incurred, or itemized receipts of payment for such expenses.**

**If future treatment is necessary, provide a statement of anticipated expenses for each treatment.**

**(4) If you claim loss of wages or income as a result of injury, state:**

_____ <b>Name of Employer</b>	_____ <b>Address of Employer</b>
_____ <b>Your Occupation</b>	_____ <b>Date You Became Employed</b>
_____ <b>Total Lost Wages to Date</b>	_____ <b>Expected Date of Return (If Out)</b>

**NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.**

**(5) Set forth any and all other losses or damages claimed by you.**

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Please provide documentary evidence showing amounts of income lost.

**c. If you claim property damage:**

**(1) Describe the property damage.**

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**(2) The present location and time when the property may be inspected.**

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**(3) Date property acquired.**

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**(4) Cost of property \$**

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**(5) Value of property at time of accident. \$**

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**(6) Description of damage.**

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**(7) Has the damage been repaired? \_\_\_\_\_ If so, by whom, when and cost of repairs.**

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**(8) Attach each estimate of repair costs to this form.**

**(9) Set forth, in detail, the loss claimed by you for property damage.**

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**d. Set forth, in detail all other items of loss or damages claimed by you and the method by which you made the calculations.**

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**5. The amount of the claim.**

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6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice? \_\_\_\_\_

If yes, set forth the name and address of all person and insurance companies against whom you have made such claims.

7. Are any of the losses or expenses claimed herein covered by any policy of insurance? \_\_\_\_\_

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

8. a. If this claim involves an automobile, please state:

(1) The name of the insurance company covering the automobile.

(2) The name of your local agent. \_\_\_\_\_

(3) Your policy number and dates of coverage (if other than auto).

b. (1) State the name of your Homeowners', rental or property insurance company

(2) The name of your local insurance agent. \_\_\_\_\_

(3) Your policy number. \_\_\_\_\_

c. If you have any other form or kind of insurance, please state:

(1) The name or names of the insurance company.

(2) Type of liability coverage. \_\_\_\_\_

(3) The name of your local agent. \_\_\_\_\_

(4) The policy number or numbers. \_\_\_\_\_

9. Have you received or agreed to receive, any money from anyone for the

damages claimed herein? \_\_\_\_\_ If so, describe details of agreement.

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10. The following items must be submitted with this notice or your claim may be rejected as incomplete:

(A) Copies of itemized bills for each medical expense and other losses and expenses claimed.

(B) Full copies of all appraisals and estimates of property damage claimed by you.

(C) Copies of all written reports of all expert witnesses and treating physicians.

(D) A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

11. Please specify, if known, whether the claim arises out of any of the following activities of:

(A) Any construction project. \_\_\_\_\_

(B) Any demolition project. \_\_\_\_\_

(C) Any road or bridge project. \_\_\_\_\_

(D) Other. \_\_\_\_\_

12. State whether the incident has occurred on any sidewalk, street or bridge located in the City of Atlantic City.

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13. If yes, please give exact location.

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Provide a list of your expert witnesses and their reports or statements relating to the claim.

Please be advised that the City of Atlantic City may require you to submit to a physical or mental examination by a physician employed by the City of Atlantic City and you may be required to permit the City of Atlantic City to inspect all appropriate records relating to your claim for liability and damages including, but not limited to, income tax returns, hospital records, medical records and employment records subject to Attorney General rules and regulations regarding same.

I, hereby certify, that the foregoing statements made by me are true, that the attached

statements, bills, reports and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made is willfully false, I am subject to punishment provided by law.

Dated:

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CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals or other medical service facility to release to the:

City of Atlantic City Solicitor's Office or its Third Party Claims Administrator or their representatives, any and all records, reports and other information concerning the treatment of the claimant named herein.

Dated:

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Name (written)

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Signature

(This form must be signed by claimant or the parents of the claimants who are minors.)

ALL INFORMATION REQUESTED IN THIS FORM MUST BE PROVIDED SO THAT FAIR AND FULL DISCLOSURE OF INFORMATION NECESSARY TO THE ORDERLY AND EXPEDIENT ADMINISTRATIVE DISPOSITION OF THE CLAIM MAY BE HAD. UNDER THE SCHEME OF THE NEW JERSEY TORT CLAIMS ACT, A GOVERNMENTAL ENTITY IS AFFORDED AT LEAST SIX MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETED CLAIM FOR TO REVIEW AND SETTLE MERITORIOUS CLAIMS. FAILURE TO PROVIDE COMPLETE ANSWERS TO ALL QUESTIONS AND/OR THE WITHHOLDING OF INFORMATION MAY RESULT IN FORFEITURE OF THE CLAIMANT(S) RIGHTS (N.J.S.59:81, et seq.).