Print Form

CLAIM FOR DAMAGES AGAINST THE TOWN OF MORRISTOWN

RECEIVED
AUG 2 0 2020
TOWN OF MORRISTOWN
TOWN CLERK'S OFFICE

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF ACCIDENT/OCCURRENCE OR YOU MAY FORFEIT YOUR RIGHTS PURSUANT TO N.J.S.A. 59:1 ET SEQ.

1. CLAIMANT INFORMATION

8/ /2020
DATE OF ACCIDENT

$ 750.00
AMOUNT OF CLAIM

SCHMITT
LAST NAME

ADAM
FIRST NAME

[redacted]
SOCIAL SECURITY NUMBER

[redacted]
ADDRESS

Single
MARITAL STATUS

0
NUMBER OF DEPENDENTS

[redacted]
DATE OF BIRTH

N/A
HOME PHONE

[redacted]
WORK PHONE

2. If notice and correspondence in connection with this claim are to be sent to a person other than the claimant, complete item No. 2.

NAME

MAILING ADDRESS

Person filling out this form and Relationship to Claimant: ☐ Attorney at Law or

Name

Relationship

3. The occurrence or accident which gave rise to this claim:

a. 8/3/2020 (Date) 1:45pm (Time)

b. MORRISTOWN (Municipality) In front of 60 Market St. Morristown NJ (Exact location of the occurrence)

c. Describe how the accident or occurrence happened. If a diagram will assist your explanation please attach hereto.

Was sitting in my living room @ [redacted] NJ and watched a town-owned tree fall on top of my car denting the roof & Door.

d. State the names of public employees and or public agencies whom you claim were at fault, including any information that will assist identifying and locating them.

Morristown DPW

e. State the negligence or wrongful acts of the public agency or its employees which allegedly caused your damages.

Tree was dead and not maintained Properly

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

N/A

g. State the names of all Police Officers and Police Departments who investigated the accident.

Sgt. Hewnemen Morristown PD

4. a. Claim for damages (check appropriate block)

- [x] Property Damages
- [ ] Personal Injury
- [ ] Other-Explain in Detail below

b. If you claim personal injury,

1. Describe your injuries resulting from this accident or occurrence.

N/A

2. Do you claim permanent disability resulting from this injury?

☐ Yes ☒ No

If yes, describe the injuries believed to be permanent.

N/A

3. Please each hospital, doctor or other practitioner's Name or Facility, Address, Dates of Treatment or Service and the Amounts of charges to date that rendered treatment, examination or diagnostic service.

N/A

N/A

N/A

N/A

5. Are you covered by any health insurance policy? If so, please advise name and address of carrier, named insured and policy number.

N/A

List bills submitted to carrier:

N/A

6. If you claim loss of wages or income as a result of the injury, state:

N/A Name of Employer	N/A Address of Employer
N/A Your Occupation	N/A Date you became employed at this job
N/A Rate of pay	N/A Dates absent from work
N/A Total lost wages to date	N/A If still out of work, expected date of return

If injury is associated with an auto accident, please provide name of auto insurance carrier and policy number.

N/A

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

7. Set forth any and all losses or damages claimed by you.

$750.00

c. If you claim property damage:
   1. Describe the property damaged.

2007 VW Golf Dents to Roof, Door, Trunk, Front fender, & Rear Bumper

3. Date property acquired: N/A

4. Cost of Property N/A

5. Value of Property at time of accident N/A

Description of Property

2002 VW GOLF TDI

Has the damage been repaired? ☐ Yes ☒ No If so, please list by whom, when and cost of repairs?

8. Attach each estimate of repair costs to this form.

9. Set forth in detail the loss claimed by you for property damage.

Vehicle Deemed total loss, requesting coverage of Deductible

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

$750.00 insurance Deductible

8. State the total amount of damages (personal, property and other) you are claiming.

$750.00

9. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice? ☒ Yes ☐ No

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

New Jersey Manufacturers Insurance

10. Are any of the losses or expenses claimed herein covered by any policy of insurance?

☒ Yes ☐ No

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

NJM 301 Sullivan Way West Trenton NJ 08628
Policy # [redacted]

11. The following items must be submitted with this notice:

1. Copies of itemized bills for each medical expense and other losses and expenses claimed.
2. Full copies of all appraisals and estimates of property damage claimed by you.
3. Copies of all written reports of all expert witnesses and treating physicians.
4. A letter from your employer verifying lost wages. If self employed, a statement showing the calculation of your claimed lost income.

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 in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by law.

Adam Schmitt

Claimant or person filing on behalf of claimant

8/18/2020

Date

MEDICAL/EMPLOYMENT INFORMATION RELEASE AUTHORIZATION

To Whom It May Concern:

I hereby authorize any and all doctors, hospitals, or other medical service facilities to release to the Town of Morristown or their representative any and all records, reports an dother information concerning the treatment of the claimant named herein.

_____
Please print name

_____
Signature

_____
Date

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

COMPLETED FORM MUST BE FORWARDED TO:

Town of Morristown
Attn: Town Clerk
P.O. Box 914
Morristown, NJ 07963-0914