City of Newport News
Report of Accident & Claim Against the City

To: Office of Self Insurance
700 Town Center Drive, Suite 230
Newport News, Va. 23606

Person/Firm making claim (full name): ______________________________

Address: ______________________________

City & State ____________________ Zip __________

Home Phone ______________ Work Phone ______________

Social Security No. ____/____/_____ DOB ______________

Are you a Medicare beneficiary? __ Yes __ No

(Above information is required if any payment is to be made)

Date of Accident/Loss ___/___/___ Time of Accident/Loss __________ ___ AM ___ PM

Location of Accident/Loss ______________________________

Description of Accident/Loss ______________________________

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Witness (if any) (name, address & phone number): ______________________________

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Name of City Employee involved: ______________________________

Type of claim being made __ Automotive Damage __ Property Damage __ Injury __ Other

<u>For Auto Damage</u>

Vehicle Owner ______________________________

Make of Auto ______________ Model __________ Color ______________

Year _______ License Plate No. ________________

Do you have insurance? __ Yes __ No Carrier: ____________ Policy #: ____________

Is there a lien on your vehicle? ___ Yes ___ No

Fill out both sides of form

If so, lien holder name, address & phone number ____

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____

For Injury

Nature of Injury ____

____

____

Were you treated? ___ Yes ___ No Did you miss time from work __ Yes __No

Name and Address of Doctor/Hospital ____

____

Are you still under treatment? ___ Yes ___ No By whom ____________________________________

Current treatment is for ____

Do you have health insurance? __ Yes ___ No

For Property Damage

Description of damage ____

Is this property insured? __ Yes ___ No By whom ____

Name/Address of Property Owner: ____

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Any additional information that you feel we should be aware of: _________________________________

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The furnishing of this form to you is for your convenience and is not an acknowledgement of liability or waiver of rights by the City of Newport News. Omission of facts may cause delay or affect the outcome of the claim so please complete fully and in detail. If you have any written repair estimates please return with this form.

Instructions: Fill out this form and return to:

City of Newport News
Office of Self Insurance
700 Town Center Drive, Suite 230
Newport News, Va. 23606

_________________________________ ____________________
Signature Date