Egg Harbor City Board of Education

730 Havana Avenue
Egg Harbor City, NJ 08215

NOTICE OF TORT CLAIM

CLAIMANT INFORMATION

Name _____ Telephone _____

Address _____ Date of Birth _____

_____ SSN _____

ATTORNEY INFORMATION (if applicable)

Name _____ Telephone

Address _____ TeleFAX

_____ File No.

Send Notices to: __ **Claimant** __ **Attorney**

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 Board of Education of the City of Egg Harbor.

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 the

Board Secretary - Business Administrator
Board of Education of the City of Egg Harbor
730 Havana Avenue
Egg Harbor City, NJ 08215

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 Board of Education of the City of Egg Harbor. 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 Notices 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 copies. 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 of the applicable question.

DEFINITIONS:

"Claimant" shall refer to the person or persons on whose behalf the Notice of Claim has been filed with the Board of Education of the City of Egg Harbor.

"Documents" shall refer to any written, photographic or electronic representation, and any copy thereof, including, but not limited to, computer tapes and/or disks, videotapes and other material relating to the subject matter of the claim.

"Person" shall include in its meaning a partnership, joint venture, corporation, association, trust or any other kind of entity, as well as a natural person.

"Public Entity" shall refer to the Board of Education of the City of Egg Harbor along with any agent, official or employee of the Board of Education against whom a claim is asserted by the Claimant.

“You” or “Your” refers to the Claimant, any employee, agent or servant of the Claimant, and anyone acting on the Claimant’s behalf, such as the Claimant’s attorney.

NOTE that the questions are divided into sections relating to the claimant, the claim, property damage, personal injury and the basis for the claim against the public entity or a public employee.

If the claim involves only property damage, then the portion on personal injuries need not be answered. Just enter as the answer to Question 20 "No personal injuries claimed."

If the claim involves no property damage, then the portion on property damage need not be answered. Just enter as the answer to Question 19 "No property damage claimed."

INFORMATION ON THE CLAIMANT

1. Provide the following information with respect to the Claimant. Note: if the Claimant is a minor, please provide the below information for the Claimant and the Claimant's parent(s) or guardian(s).

    a. Date of birth.

    b. Social Security number.

    c. Driver's license number.

    d. Email address(es).

    e. Address at the time of the incident giving rise to the claim.

    f. Identify each person residing with the claimant and the relation, if any, of the person to the Claimant.

    g. Any other name(s) by which the Claimant has been known.

    h. Marital Status, now and at the time of the incident, and name of spouse.

2. Provide all addresses of the Claimant for the last 10 years, the dates of the residence, the persons residing at the addresses at the same time as the Claimant resided at the address and the relation, if any, of the person to the Claimant.

3. Provide the name and address of Claimant's current employer, and all employers for the prior ten (10) years.

4. If the Claimant is currently a student, please identify the school where Claimant is currently enrolled, and any other schools Claimant has attended for the prior ten (10) years.

INFORMATION ON ALL CLAIMS

5. Provide the exact date, time and place of the incident forming the basis of the claim and the weather conditions prevailing at the time.

6. Provide the Claimant's complete version of the events that form the basis of the claim.

7. List any and all individuals who were witnesses to or who have knowledge of the facts of the incident which gave rise to the claim. Provide the full name, address, telephone number and email address of each individual (to the extent known).

8. Identify all public entities or public employees, by name and position, alleged to have caused the injury or property damage **and specify as to each public entity or employee the exact nature of the act or omission alleged to have caused the injury or property damage.**

9. If you claim that the injury or property damage was caused by a dangerous condition of property under the control of the public entity, specify the nature of the alleged dangerous condition and the manner in which you claim the condition caused the injury.

10. If you allege a dangerous condition of public property, state the specific basis on which you claim that the public entity was responsible for the condition and the specific basis and date on which you claim that the public entity was given notice of the alleged dangerous condition. Statements such as "should have known" and "common knowledge" are insufficient.

11. If you or any other party or witness consumed any alcoholic beverages, drugs or medications within twelve (12) hours before the incident forming the basis of the Claim, identify the person consuming the same and for each person (a) what was consumed (b) the quantity thereof (c) where consumed (d) the names and addresses of all persons present.

12. If you have received any money or thing of value for your injuries or damages from any person, insurance company, firm or corporation, state the amounts received, the dates, names and addresses of the payors. Specifically list any policies of insurance, including policy number and claim number, from which benefits have been paid to you or to any person on your behalf, including doctors, hospitals or any person repairing damage to property.

13. If you have had any communication with any employee, agent or servant of [Board of Education] related to the claim or incident giving rise to the claim, please identify the date, the person you communicated with, a description of the communication, and if in writing please produce a copy. If you recorded any conversation, please produce a copy.

14. If any photographs, video, audio, sketches, charts or maps exist with respect to anything which is the subject matter of the claim, state the date thereof, the names and addresses of the persons making the same and of the persons who have present possession thereof. Attach copies of any of these items in your possession.

15. If you or any of the parties to this action or any of the witnesses made any statements or admissions, set forth what was said; by whom said; date and place where said; and in whose presence, giving names and addresses of any persons having knowledge thereof.

16. State the total amount of your claim and the basis on which you calculate the amount claimed.

17. Provide copies of all documents, memoranda, correspondence, reports (including police reports), etc. which discuss, mention or pertain to the subject matter of this claim.

18. Provide the names and addresses of all persons or entities against whom claims have been made for injuries or damages arising out of the incident forming the basis of this claim and give the basis for the claim against each.

PROPERTY DAMAGE CLAIMS

19. If your claim is for property damage, attach a description of the property damage and an estimate of the costs of repair. If your claim does not involve any claim for property damage, enter "None".

_____ If your claim is for property damage only, initial here and proceed directly to page 11 and sign the Certification.

PERSONAL INJURY CLAIMS

20. Was any complaint made to the public entity or to any official or employee of the public entity. State the time and place of the complaint and the person or persons to whom the complaint was made.

21. Describe in detail the nature, extent and duration of any and all injuries.

22. Describe in detail any injury or condition claimed to be permanent.

23. In confined to any hospitals, state name and address of each and the dates of admission and discharge. Include all hospital admissions prior to and subsequent to the alleged injury and give the reason for each admission.

24. If an X-Ray, MRI, CT Scan or any other study was taken, state (a) the address of the place where each was taken (b) the name and address of the person who took them (c) the date when each was taken (d) what each disclosed (e) where and in whose possession they now are. Provide a copy of all such studies.

25. If treated by doctors, including psychiatrists or psychologists, state (a) the name and present address of each doctor (b) the dates and places where treatments were received (c) the nature of the treatment (d) the date of last treatment or, if treatments are continuing, the schedule of continuing treatments. Provide true copies of all written reports rendered to you or about you by any doctors who you propose to have testify on your behalf.

26. If you have any physical impairment which you allege is caused by the injury forming the basis of your claim and which is affecting your ordinary movements, hearing or sight, state in detail the nature and extent of the impairment and what corrective appliances, support or device you use to overcome or alleviate the impairment.

27. If you claim that a previous injury has been aggravated or exacerbated, describe the injury and give the name and present address of each doctor who treated you for the condition, the period during which treatment was received and the cause of the previous injury. Specifically list any impairment, including use of eyeglasses, hearing aid or similar device, which existed at the time of the injury forming the basis of the claim.

28. List all injuries in the last 5 years.

29. Identify the name and address of your family physician. **Note:** an authorization for your family physician's chart is at the end of this questionnaire. Please complete and return.

30. If any treatments, operation or other form of surgery in the future has been recommended to alleviate any injury or condition resulting from the incident which forms the basis of the claim, state in detail (a) the nature and extent of the treatment, operation or surgery (b) the purpose thereof and the results anticipated or expected (c) the name and address of the doctor who recommended the treatments, operation or surgery (d) the name and address of the doctor who will administer or perform the same (e) the estimated medical expenses to be incurred (f) the estimated length of time of treatments, operation or surgery, period of hospitalization and period of convalescence (g) all other losses or expenditures anticipated as a result of the treatments, operation or surgery (h) whether it is you intention to undergo the treatments, operation or surgery and the approximate date.

31. Itemize any and all expenses incurred for hospitals, doctors, nurses, x-rays, medicines, care and appliances and indicate which expenses were paid by any insurance coverage.

32. If employed at the time of the alleged injury forming the basis of the claim state (a) the name and address of the employer (b) position held and the nature of the work performed (c) average weekly wages for the year prior to the injury (d) period of time lost from employment, giving dates (e) amount of wages lost, if any. List any sources of income continuation or replacement, including, but not limited to, worker's compensation, disability income, social security and income continuation insurance.

33. If other loss of income, profit or earnings is claimed, state (a) total amount of the loss (b) give a complete detailed computation of the loss (c) the nature and dates of loss.

34. If you are claiming lost wages (a) the date that the employment began (a) the name and address of the employer (c) the position held and the nature of the work performed (d) the average weekly wages. Attach copies of pay stubs or other complete payroll record for all wages received during the past year.

PRIOR CLAIMS

35. Have You every brought or filed a claim for personal or bodily injury, such as a lawsuit or workers compensation claim? If you have, please identify the (a) date of the injury giving rise to the claim; (b) the injuries sustained; (c) the person or entity you brought the claim against; (d) if you were represented by an attorney, the name and address of your attorney; (e) whether the claim settled or proceeded to trial; and (f) what you received from the settlement or trial of the claim.

DOCUMENT REQUEST: Produce all documents identified in your answers to the above questions, or which you relied upon to answer the above questions.

CERTIFICATION

I hereby certify that the information provided is the truth and is the full and complete response to the questions, to the best of my knowledge.

_____
Signature of Claimant

Dated: _____

AUTHORIZATIONS

INSTRUCTIONS: If you are claiming bodily or personal injury, complete, sign and return the following forms.

Complete and sign one (1) medical authorization for each doctor who provided you with any treatment for your injuries, as well as for your family physician, whether or not they provided you any treatment for your injuries.

If you are claiming property damage only, you do not need to complete the following forms.

AUTHORIZATION FOR RELEASE OF EMPLOYMENT RECORDS

TO: _____ Date: _____
[name of your employer]

RE: _____
[your name]

_____
Address

_____

_____
Social Security Number

_____
Claim Number

You are hereby authorized and requested to disclose, make available and furnish to:

Qual-Lynx
100 Decadon Drive
Egg Harbor Township, NJ 08234

Phone: 609-653-8400
Fax: 609-926-9270

all information relating to my employment, including, but not limited to, my job title, assigned duties, compensation, benefits, attendance, and sick leave and to permit him or her to inspect and make copies or abstracts thereof.

A photocopy of this release form, bearing a photocopy of my signature, shall constitute your authorization for the release of the information in accordance with the request made to you.

_____
Signature

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

(please print)

Patient Name: _____ DOB: _____

PatientAddress:_____

City: _____ State: _____ Zip: _____

I hereby authorize:_____

(Name of physician's office/medical practice disclosing information)

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to:

Qual-Lynx
100 Decadon Drive
Egg Harbor Township, NJ 08234

Phone: 609-653-8400
Fax: 609-926-9270

Please indicate the information or types of information to be disclosed: any and all medical records in your possession, including but not limited to any and all office notes, medical records, reports, diagnostic studies, hospital records, operative reports, psychiatric and/or psychological records, bills etc.

Specify dates (or date range) if applicable:

This request is for the purpose of investigation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in two years or on the following date: _____.

I understand that any disclosure of information may be subject to re-disclosures by the recipient and may no longer be protected by federal state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.
IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE _____

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

A copy of this signed form will be provided to the claimant patient.
Photocopies of this Authorization carry the same authority as the original.

_____ _____
Signature of Patient of Authorized Representative Date

_____ _____
Description of Representative's Authority Signature of Witness
(witness signature required)

File # _____

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

SECTION I

1. FULL NAME (Please Print exactly as it appears on your Medicare or Social Security Card.

2. ADDRESS

3. HOME TELEPHONE NUMBER

4. DATE OF BIRTH (01/01/1999)

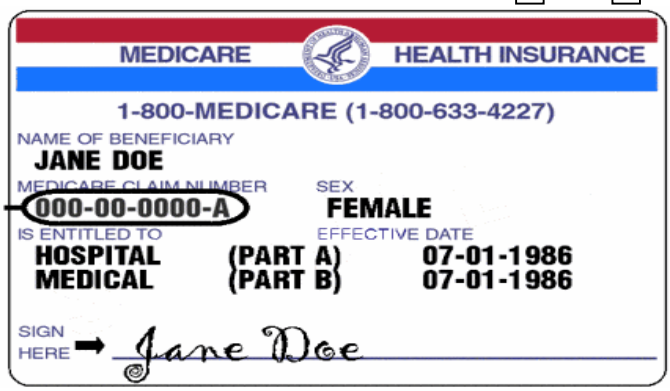
5. SEX

MALE ☐ FEMALE ☐

6. SOCIAL SECURITY NUMBER

7. Are you presently or have you ever been enrolled in Medicare Part A or Part B ☐YES ☐NO

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



8. MEDICARE CLAIM NUMBER:

SECTION II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____ **Claim Number** _____

Name of Person Completing This Form If Claimant is Unable (Please Print)

_____

Signature of Person Completing This Form _____ **Date** _____

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____ _____

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____

_____

_____

_____

_____ _____

Signature of Person Completing This Form **Date**