PORT OF OLYMPIA| TORT CLAIM FORM PACKET

Please carefully read all of the information in this packet before completing and submitting your Standard Tort Claim Form ("Claim Form"). Please note no documents will be returned.

Documents Contained in the Claim Form

1. Instructions for Completing the Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Mandatory Medicare Beneficiary Reporting Form

Presenting a Tort Claim Form

Washington law requires citizens wishing to bring a claim against a local government entity to first present a tort claim form with the government at issue. The law also requires government entities to provide citizens with access to the tort claim form with instructions. In compliance with these requirements and for the convenience of citizens, the Port has prepared the following standard Claim Form.

Legal Requirements for Presenting a Tort Claim Form

In order to verify the claim and additional supporting information, the Claim Form must be signed by either:

1. The claimant;
2. A person holding written power of attorney from the claimant;
3. An attorney admitted to practice in Washington State on the claimant's behalf; or
4. A court-appointed guardian ad litem on behalf of the claimant.

Form presented without proper signature will be rejected. Please be sure to type or print clearly in ink.

Submit the Claim Form and Supporting Documents by mail or in person to:

Port of Olympia
Attn: Ben McDonald
606 Columbia Street NW, Suite 300
Olympia, WA 98501
BenM@portolympia.com

Business Hours: Monday-Friday, 8:00 a.m. to 5:00 p.m.
Closed on weekends and official State Holidays.

The claim for damage form must be signed and notarized

INSTRUCTIONS FOR COMPLETING THE PORT OF OLYMPIA CLAIM FOR DAMAGE FORM

Before filing a Claim for Damage please read these instructions and the Claim for Damage form in its entirety.

The Claim for Damage form must be signed and notarized. Type or print clearly in ink and sign the Claim for Damage form. If you are incapacitated, a minor or a non resident of the state, a relative, attorney or agent may sign on your behalf.

Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

The following are **examples** on how to complete the Claim for Damage form:

(1) Doe, John Conner, 12/01/1910

(2) 222 One Way Street, Apt. Z, Olympia, Washington 98501

(3) Post Office Box 111, Olympia, Washington 98501

(4) Same

(5) (360) 555-5555

(6) January 1, 2009, 8:00 a.m.

(7) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item (7).

(8) Washington, Thurston, Olympia, parking lot of Port of Olympia offices.

(9) Fitzgerald III, Mortamer, 3287 Wonderful Lane, Olympia, Washington 98501, (360)111-1111; tow truck driver, XYZ Towing.

(10) Unknown

(11) List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items (11) and (12). Also include a description of their knowledge. For example if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.

(12) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.

(13) If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.

(14) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include medical records and bills.

(15) Attach documents which support the claim's allegations.

(16) Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss etc. This amount should represent your opinion of total compensation.

(17) If you were injured, please complete the Medicare Verification form (please contact District for form).

Submit the completed and notarized form to Ben McDonald at benm@portolympia.com
or by mail to Port of Olympia, Attention: Ben McDonald, 606 Columbia Street NW Suite 300, Olympia, WA 98501.
A confirmation receipt will be returned to the claimant.

THE CLAIM FOR DAMAGE FORM MUST BE SIGNED AND NOTARIZED

PORT OF OLYMPIA CLAIM FOR DAMAGE FORM

Under penalty of law, Enduris intends to prosecute all false claims.

CLAIMANT INFORMATION

(1) Claimant's Name:_____
(Last Name) (First) (Middle) (Date of Birth: mm/dd/yyyy)

(2) Current Residential Address: _____
_____,

(3) Mailing Address (if different): _____
_____,

(4) Residential Address for Six Months Prior to the Date of the Incident (if different from current address):

_____

(5) Claimant's Daytime Phone Numbers: Home Phone # _____, Business/Cell #_____
_____,
Claimant's Email Address: _____

INCIDENT INFORMATION

(6) Date of Incident: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:
From: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)
To: _____ Time: _____ ❑a.m. ❑p.m. (check one)
(mm/dd/yyyy)

(8) Location of Incident: _____
(city/state) (place where occurred)

(9) If the incident occurred on a street within the Port of Olympia boundaries:
_____
(name of street) (at intersection with or nearest intersecting street)

(10) District or agency alleged responsible for damage/injury: Port of Olympia

(11) Names, address, and telephone numbers of all persons involved in or witness to this incident:
_____
_____

(12) Name, addresses, and telephone numbers of all district or agency employee having knowledge about this incident:
_____
_____

(13) Names, addresses, and telephone numbers of all individuals not already identified in (11) and (12) above that have knowledge regarding the liability issues involved in this incident, or knowledge of the claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.
_____
_____

(14) Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.
_____
_____

(15) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

_____

_____

(16) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

_____

_____

(17) Please attach documents which support the claim's allegations.

(18) I claim damages in the amount of $_____

(19) If you are injured, are you a Medicare beneficiary? ❑Yes ❑No (check one) If Yes, please complete the Medicare Verification form.

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate #_____ Driver License # _____

Type Auto: _____
(year) (make) (model)

DRIVER:
Address: _____

Phone #: _____

OWNER:
Address: _____

Phone #: _____

PASSENGERS:
Name: _____
Address: _____

Name: _____
Address: _____

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

NOTE: THIS FORM MUST BE SIGNED AND NOTARIZED

I, _____, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X _____

X_____
Signature of Claimant(s)

Subscribed and sworn to before me this _____day of _____, 20 ___.

_____NOTARY PUBLIC in and for the State of Washington

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 to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), a 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 help CMS to properly coordinate payment of benefits among plans so that your medical claims are paid promptly and correctly.

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

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

Please note the Medicare Number located on this card.

Section I

Are you presently, or have you ever been, enrolled in Medicare?			☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.				
***Full Name:** (Please print the name exactly as it appears on your SSN or Medicare card if available.)*				
Medicare Number:		**Date of Birth (Mo/Day/Year)**	/ /	
****Social Security Number:** (If Medicare Number is Unavailable)	- -	**Sex**	☐ Female	☐ Male

** Note: If you are unable to provide your Medicare Number **and** uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last **5** digits of your SSN in the section above.

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)

_____

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)

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**