



## CLAIM FOR DAMAGES

Please closely follow the instructions below to resolve your claim as quickly as possible. We ask that you complete each item on the checklist before submitting your documents. Unfinished or incomplete submittals will delay the process. If you have questions, contact Tsz Yan Brady at 425-774-0549.

### WHAT IS THE DOLLAR AMOUNT OF YOUR CLAIM?

Less than \$150.00 USD (Follow the checklist in section 1a)

More than \$150.00 USD (Follow the checklist in section 1b)

### 1A. INSTRUCTIONS FOR CLAIM AMOUNTS UNDER \$150.00

On page 1:

Complete line 1

Complete line 2

Complete line 3

Complete 5

Complete line 6 or 7

Complete line 14

Complete line 18

Sign and date the document (bottom of page 2)

Attach an estimate for repair or receipt for repair if already completed

When complete, follow the submission instructions.

### 1B. INSTRUCTIONS FOR CLAIM AMOUNTS OVER \$150.00

Completely fill out all applicable lines on pages 1 and 2 (items 1-19).

Attach an estimate for repairs.

If the claim involves personal injuries, complete page 3.

The form must be notarized for the Port to accept the claim. We have two notaries on staff that can complete this for free. Call to schedule an appointment time. Please note that we cannot reimburse third party notary fees.

When complete, follow the submission instructions.

## 2. SUBMISSION INSTRUCTIONS

Please ensure that you have completed all the required steps in 1A or 1B; unfinished forms will slow the claim process. When you are ready to send the paperwork, we ask that you use one of the following options.

**Email:** [tbrady@portofedmonds.gov](mailto:tbrady@portofedmonds.gov)

**Mail:** Port of Edmonds  
Attn: Tsz Yan Brady, Claims Agent  
471 Admiral Way  
Edmonds, WA 98020

**In Person:** Port of Edmonds Administration Office  
471 Admiral Way  
Edmonds, WA 98020

**Fax:** 425-774-7837

Please find additional directions and guidance on the next page. Once the claim form is submitted, you can expect a phone call or email confirmation receipt from Tsz Yan Brady within three business days. Also, note that an insurance adjuster may reach out for additional information.

If you have questions, please contact Tsz Yan Brady at 425-774-0549.

## **INSTRUCTIONS FOR COMPLETING THE 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, Seattle, Washington 98178
- (3) Post Office Box 111, Seattle, Washington 98178
- (4) Same
- (5) (206) 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, Tumwater, parking lot of XYZ Cleaners.
- (9) I-5, southbound, Milepost, near XYZ Exit. (10) XYZ Barone Sanitation
- (11) Fitzgerald III, Mortamer, 3287 Wonderful Lane, Seattle, Washington 98187, (360)111-1111; tow truck driver, XYZ Towing.
- (12) Unknown
- (13) 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.
- (14) Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when, and why.
- (15) 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.
- (16) 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.
- (17) Attach documents which support the claim's allegations.
- (18) 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.
- (19) If you were injured, please complete the Medicare Verification form (attached).

**THE CLAIM FOR DAMAGE FORM MUST BE SIGNED AND NOTARIZED**

**Mail or Deliver Original Claim to:**

**Agent to Receive Claim** Tsz Yan Brady **Address** 471 Admiral Way  
**District** Port of Edmonds Edmonds, WA 98020  
**Business Hours** 8:00am – 4:30pm Monday to Friday

**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: \_\_\_\_\_  
(state and county) (city if applicable) (place where occurred)
- (9) If the incident occurred on a street or highway: \_\_\_\_\_  
(name of street/highway) (mile post) (at intersection with or nearest intersecting street)
- (10) District or agency alleged responsible for damage/injury: \_\_\_\_\_
- (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.

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



**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