PORT OF EDMONDS

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. Estimate must be from a third-party vendor qualified to do the work. Please note that any personal labor costs incurred by the claimant will not be reimbursed.

☐ 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. All materials and labor must be from a third-party vendor, qualified to do the work. Please note that any personal labor costs incurred by the claimant will not be included in the settlement amount.

☐ If the claim involves personal injuries, complete pages 3 & 4.

☐ 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. SUBMSISSION 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

☐ **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
District Port of Edmonds
Business Hours 8:00am – 4:30pm Monday to Friday

Address 471 Admiral Way
Edmonds, WA 98020

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:	**OWNER:**
Address: _____	Address: _____
_____	_____
Phone #: _____	Phone #: _____
PASSENGERS:	
Name: _____	Name: _____
Address: _____	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

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**