This is a Fill-In Form. Please fill in and print. Print Form Clear Form

CLAIM AGAINST THE CITY OF MOUNTAIN VIEW, CA

Pursuant to Government Code 910, subject to certain limited exceptions, a claim must be filed with the City of Mountain View within six (6) months of the incident. Completed claims must be mailed or hand-delivered to the **City Clerk's Office, 500 Castro Street, P.O. Box 7540, Mountain View, California, 94039**. E-mailed or faxed claims will not be accepted. Please complete each section and print clearly. This claim form is a public record and shall be provided upon request in conformance with the Public Records Act, Government Code Sec. 6250 *et seq*.

Attach copies of itemized receipts, estimates, photographs or other documentation of your claim.

Claimant's Full Legal Name: _____

Date of Birth: _____-_____-_____ Driver's License: State: _____ No.: _____

Gender: ☐ Male or ☐ Female

Home/Cell Phone: _____ Business Phone: _____

Claimant's Address: _____

Street Apt. No.

_____

City State Zip Code

Post Office Address Where Notices Should be Sent if Different from Claimant's Address: _____

Street

_____

City State Zip Code

Date of Incident: _____-_____-_____ Time of Incident: _____ ☐ AM or ☐ PM

Location of Incident: _____

CAUSE OF LOSS: Detailed description of the event, act or omission which you allege caused the injury or damage for which you are submitting this claim. Please use additional paper if necessary:

Continue to Page 2

Name(s) of Public Employee(s) causing injury, damage, or loss: _____

_____

Name and telephone number of any known witnesses: _____

_____

DESCRIPTION OF LOSS (Describe injury, property damage, or loss. If there were no injuries, state "NO INJURIES."):

Amount Claimed: $_____
and Basis for Computation:

The Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report Social Security Numbers (SSNs) in order for Medicare to coordinate payments with other insurance benefits. Individuals who receive ongoing reimbursement for medical care through no-fault insurance, Workers' Compensation, or who receive a settlement, judgment, or award from liability insurance/self-insurance or Workers' Compensation, will be asked to furnish information concerning their SSN. In order for the City to comply with the mandatory reporting requirements of the Medicare, Medicaid, and SCHIP Extension Act of 2007, the following information is required:

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

IF YES, PROVIDE MEDICARE NUMBER _____

Disclosure of your SSN is required if your claim is for personal injury pursuant to the Medicare, Medicaid, and SCHIP Extension Act (Public Law 110-173 Section 111). The Federal Government requires the City to report settlements for present or future medical care. This information will be kept confidential and only shared with the Federal Government. The City is unable to process payment without this information. If your claim is not for personal injury, disclosure of your SSN is voluntary.

SOCIAL SECURITY NUMBER _____

I certify that the forgoing is true and correct. Submitted by:

_____
Date

_____
Claimant Name or Attorney Representing Claimant

Sign here after printing.
Claimant Signature or Attorney Representing Claimant

WARNING: It is a criminal offense to intentionally file a false or fraudulent claim and is punishable by imprisonment for up to one (1) year or a fine of up to $10,000, or both (Penal Code Section 72).