

**Administrative Services**

Phone: (740) 203-1025

Fax: (740) 203-1049

Proof of Loss Claim Form

1. General Information:

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Work Phone (_____) _____

Employer _____

Address _____

City _____ State _____ Zip Code _____

2. Date of Incident: _____**3. Location Incident Occurred:** _____**4. Property Damage:***Two written estimates for each item to be repaired must accompany this claim form.*

Name/description of item	Date purchased	Description of damage	Cost of repair

5. Medical Expenses:

Please enclose copies of each medical bill itemized.

Doctor/Hospital (include name and address)	Amount
_____	_____
_____	_____
_____	_____

6. Description of how injury or loss occurred. Please be specific:

7. Witnesses:

Name	Address/City/State/Zip	Phone
_____	_____	_____
_____	_____	_____

8. Insurance Coverage:

Failure to complete this section may result in delay of your claim.

Name of Carrier _____ Policy Number _____

Mailing Address _____ Phone (____) _____

Are you required to pay a deductible? _____

If so, how much? _____

9. Are you aware of any other party who may have been responsible for your loss? If so, please list that information here:

Name _____

Address _____

City _____ State _____ Zip Code _____

10. If you are claiming property damage, were you the owner of the property? _____

11 Are you involved in any other claim(s), lawsuits(s), or dispute(s) with the City of Delaware? If so, please list details here:

12. Are you currently indebted to the City of Delaware (i. e. tax bills, utility bills, traffic tickets, etc.)? If so, please explain here:

IMPORTANT: Any person who with intent to defraud or knowing that they are facilitating a fraud against any individual or corporation, public or private, submits documentation in filing a claim containing false or deceptive statements is guilty of fraud.

Signature _____ Date _____