

INSTRUCTIONS: Statute of Limitations is one year, if death is involved, two years. Give complete information and **attach all requested documentation** and any other information to substantiate your claim. The burden of proof rests with the claimant. Failure to provide complete information may affect the decision of your claim. **ALL CLAIMS MUST BE SIGNED AND NOTARIZED.** Submit two complete sets to: **STATE BOARD OF ADJUSTMENT, ALABAMA STATE CAPITOL, THIRD FLOOR EAST WING, MONTGOMERY, AL 36130-1435. PHYSICAL MAILING ADDRESS: 600 DEXTER AVENUE, SUITE 302, MONTGOMERY, AL 36104.**

Do not write in this space

CLAIM NO.: _____
SUPPLEMENT NO.: _____

If a SUPPLEMENT to a previously filed claim, give Claim Number: _____

Name of Department/Agency

1. Name & Mailing Address of Claimant: _____

Home Telephone: _____ Business Telephone: _____

Social Security/Federal I.D. No. (Required for issuance of state check): _____

If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FILED BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.

2. Claimant's Attorney (If representing claimant on this claim): _____

Mailing Address: _____

_____ Zip: _____ Telephone _____

Note: All correspondence and communication will be with claimant's attorney.

3. Date of Accident or injury: _____

4. If not accident or injury, on what date did claim arise? _____

5. Where did injury or damage occur ? _____
(county, city, building name, etc.)

6. **Statement of Facts:** Give the name of the department or agency of the State of Alabama involved. Tell in your own words exactly what happened to cause you to file this claim. **Attach a copy of accident/incident report.**

Prior Fiscal Year Invoices Yes No Travel Expense Yes No Other Yes No

Explain below.

Invoice/Reference # _____

Facts: _____

(Attach additional sheets if needed.)

7. **IS CLAIM MADE FOR:** (Complete only those parts which apply to this claim.)

(A) **UNINSURED MEDICAL EXPENSES?** Yes No

Was this an on-the-job injury? Yes No

Did you receive any time off with pay? Yes No If yes, give dates: _____

Amount: \$ _____ Do you have insurance? Yes No Company: _____

All medical expenses must be submitted to your insurance company: **Attach documentation to support the amount claimed, such as itemized bills and insurance company statement (s) showing the expenses have been filed and the amount paid or payable by insurance.**

(B) **PERMANENT DISABILITY?** Yes No

Amount: \$ _____

Describe: _____

Attach detailed statement by a doctor or vocational expert describing extent of disability

Rate of pay at time of accident/injury: \$ _____

Attach verification from employer.

(C) **LOST WAGES AND/OR COMPENSATION FOR LEAVE USED?** Yes No

Amount: \$ _____ for _____ hrs./days/weeks/etc.

Period (dates) for which claim is made: _____

Rate of pay at time of accident/Injury: \$ _____

Attach doctor's excuse for dates missed from work. Attach verification of dates and rate of pay from employer.

8. **DAMAGES TO PERSONAL PROPERTY?** Yes No

Amount: \$ _____

Attach bills, receipts, etc. to substantiate amount claimed. If automobile, attach two estimates of repair costs.

Describe property: _____
(year/make/model of vehicle, watch, eyeglasses, clothing, etc.)

Do you have insurance which would cover all or part of the damage? Yes No

If yes, give name of insurance company: _____

Amount of coverage: _____ Deductible: _____
(Please attach copy of declaration page.)

Have you filed for coverage to which you are entitled under your policy? Yes No

9. **MISCELLANEOUS/OTHER EXPENSES?** Yes No

Amount: \$ _____

Explain: _____

Attach documentation to substantiate.

10. **TOTAL AMOUNT CLAIMED:** \$ _____

This amount must be stated.

11. No part of this claim has been assigned by me and no amount has been paid to or received by me in payment for any damages/injury complained of herein except as set out as follows: (List amounts received from insurance or any other sources.)

12. Signature of claimant/representative: _____

Must bear original signature (not a machine copy) of claimant or his/her representative.



STATE OF _____ }

COUNTY OF _____ }

AFFIDAVIT

Before me, a Notary Public in and for said state and county, personally appeared _____ who being made known to me, and being informed of the contents of this petition and the statements by him/her therein, and being duly sworn, says such statements are true and correct.

Sworn and subscribed before me this _____ day of _____, 20 _____.

Signature and Seal of Notary Public