

Standard Tort Claim Form Packet

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim.

A New Law that Impacts Presenting a Standard Tort Claim Form

RCW 4.92.100 requires citizens to present the Standard Tort Claim form with the government agency named in their claim. The law also requires State and local government agencies to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, the State Office of Financial Management (OFM) developed a Standard Tort Claim Form Packet.

Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions
5. Mandatory Medicare Beneficiary Reporting Form

Legal Requirements for Presenting Standard Tort Claim Forms

In order to verify the claim and additional supporting information, the law requires that the Standard Tort Claim form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney in fact for the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- A court-approved guardian or guardian ad litem on behalf of the Claimant

Present in Person or Mail the Standard Tort Claim Form and Supporting Documents to:

Mail to:

Northshore Utility District
Attn: General Manager
6830 NE 185th St.
PO Box 82489
Kenmore, WA 98028-0489

INSTRUCTIONS FOR COMPLETING A STANDARD TORT CLAIM FORM

Before presenting a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form, and other appropriate forms in their entirety.

Type or print clearly in ink and sign the Standard Tort Claim form.

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 Standard Tort Claim form can be easily read and understood.

The following are examples on how to complete the Standard Tort Claim Form:

1. Doe, John William
2. 1234 Main St, Apt. 56, Kenmore, WA 98028
3. PO Box 910, Kenmore, WA 98028
4. Same (or residence at the time of incident)
5. 425-123-4567
6. jdoe@your-email.com
7. 8:00 a.m., August 9, 2008
8. 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
9. Washington, King, Kenmore, Northshore Utility District, Parking Lot
10. If applicable, I -5, Southbound, Milepost 109, near the Martin Way Exit
11. Northshore Utility District
12. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Towing Company Name
13. List employee names if known or enter "Unknown"
14. 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.
15. 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 your medical records and bills.
16. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
17. 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.
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.

If you are presenting a personal injury claim, please sign and attach the Medical Release form.

If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

STANDARD TORT CLAIM FORM

General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against the Northshore Utility District. Some of the information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Pursuant to the new law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail to: Northshore Utility District
Attn: General Manager
6830 NE 185th St.
PO Box 82489
Kenmore, WA 98028-0489

Present in Person to: Attn: General Manager
Northshore Utility District
6830 NE 185th St.
PO Box 82489
Kenmore, WA 98028-0489

Business Hours: Mon. - Fri. 8:00 a.m. - 4:30 p.m.
Closed on weekends and official state holidays.

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 at the time of the incident (if different from current address):

5. Claimant's Contact Information: _____
Phone Number Email Address

INCIDENT INFORMATION

7. Date of the incident: _____ Time: _____ a.m. p.m. (circle one)
(mm/dd/yyyy)
8. If the incident occurred over a period of time, date of first and last occurrences:
from _____ Time: _____ a.m. p.m. (circle one) to _____ Time: _____ a.m. p.m. (circle one)
(mm/dd/yyyy) (mm/dd/yyyy)
9. Location of incident: _____
State and county City, if applicable Place where occurred
10. If the incident occurred on a street or highway:

Name of street or highway Milepost number At the intersection with or nearest intersecting street
11. In addition to the Northshore Utility District, state any other parties responsible for damage/injury:

12. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

13. Names of all Northshore employees having knowledge about this incident:

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 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.

15. 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.

16. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? Please attach a copy of the report or contact information.

17. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

18. I claim damages from the Northshore Utility District in the sum of \$ _____

19. Please attach documents which support the claim's allegations.

This Claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

Date and place (residential address, city and county)

Signature of Representative

Date and place (residential address, city and county)

Print Name of Representative

Bar Number (if applicable)

**Authorization for Release of Protected Health Information
(PHI) to
The Northshore Utility District**

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month ____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to the NorthshoreUtility District for purposes of processing my claim for damages.

I understand that by signing this document, I authorize the release of the following information:

Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.

HIV Test Results and medical information related to HIV testing or treatment.

Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment.

Alcohol assessment, testing, referral or treatment records.

All other chemical dependency assessment of treatment records.

Pharmacy prescriptions and reports.

All letters and memos received or sent, including electronic mail, referencing my treatment. Information related to alleged sexual assault or sexually transmitted disease, including test results.

Urgent care, outpatient or other clinic visit information.

Gynecological and/or obstetrical information.

All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: _____.

Financial records related to my care and treatment.

I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

_____ I understand that my records are protected under HIPAA/PHI regulations (federal law) and the
Initials Washington State Health Care Information Act (RCW 70.02).

_____ I understand that my health information may be subject to re-disclosure by Northshore Fire
Initials Department and not protected for purposes of evaluating and investigating the claim I have filed with
the Northshore Fire Department.

_____ I understand that the specific information to be disclosed in my medical record may include
Initials information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a
history of testing or treatment of acquired immune deficiency syndrome.

_____ I understand that I may revoke this authorization at any time by notifying Northshore Utility District
Initials in writing, and that the revocation will be effective as of the date the Northshore Utility District
receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the
revocation will be deemed authorized by me for release.

_____ I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also
Initials authorize a different time frame for this release to be valid. This permission is valid until my claim is
resolved or closed by Northshore Utility District.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to the Northshore Utility District.

Signature of Authorizing Individual: _____

Date of Signature: _____

Telephone number: _____

Witness (where patient is over 13 and signing the release)

Where the signer is not the subject of the records: I am authorized to sign this because I am the
(attach proof of authority):

- _____ Parent of minor
- _____ Legal Guardian
- _____ Personal Representative
- _____ Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Attn: General Manager
Northshore Utility District
6830 NE 185th St.
PO Box 82489
Kenmore, WA 98028-0489

MMSEA REPORTING COMPLIANCE DECLARATION

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 not to inconvenience the beneficiary and recover after the 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 like the state of Washington), no-fault insurers, and workers’ compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly. Please 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.



Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If yes, please complete the following. If no, proceed to Section II.</i>		
Full Name: <i>(Please print the name exactly as it appears on the SSN or Medicare card if available.)</i>		
Medicare Claim Number:	Date of Birth (Mo/Day/Year)	
Social Security Number: <i>(If Medicare Claim Number is Unavailable)</i>	-	-
	Sex	Female <input type="checkbox"/> Male <input type="checkbox"/>

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)	Claim Number
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)	Claim Number
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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
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VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

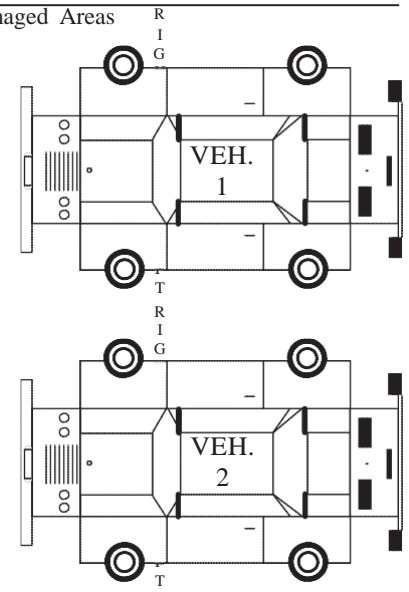
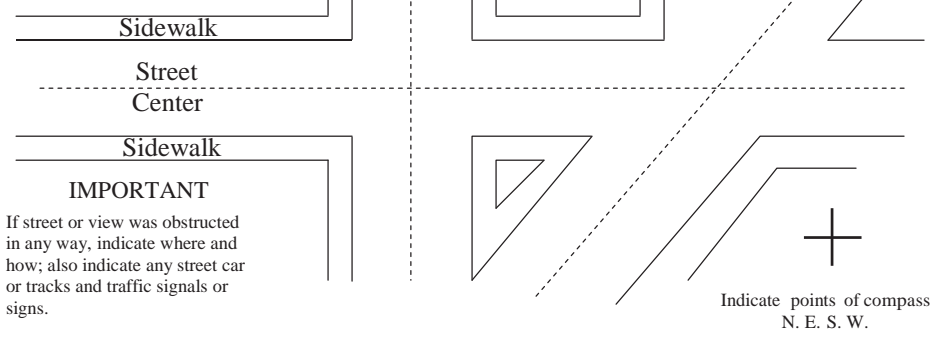
CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT (mm/dd/yyyy)		TIME AM <input type="checkbox"/> PM <input type="checkbox"/>							
	CURRENT STREET (RESIDENCE) ADDRESS				CITY		STATE ZIP							
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT				CITY		STATE ZIP							
	State/County/City (if applicable) where occurred		STREET OR HWY		MILEPOST NO.		INTERSECTION OR NEAREST STREET/ROAD							
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN CAR BE SEEN?		WHEN?							
	NAME OF VEHICLE OWNER			ADDRESS		CITY		HOME AND WORK PHONE						
	NAME OF DRIVER			ADDRESS		CITY		HOME AND WORK PHONE						
	DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE			DATE OF EXPIRATION							
	DESCRIBE DAMAGE					ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.							
	YEAR	MAKE	MODEL	LICENSE PLATE NO.	STATE AGENCY, IF KNOWN									
NAME OF OWNER			ADDRESS		CITY		PHONE							
NAME OF DRIVER			ADDRESS		CITY		PHONE							
DESCRIBE DAMAGE							ESTIMATE \$							
OTHER NON-VEHICLE DAMAGE														
WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.														
NAME OF OWNER			ADDRESS		CITY		PHONE							
DESCRIBE DAMAGE							ESTIMATE \$							
INJURED PARTIES	NAME		ADDRESS		PHONE		INJURY		AGE	VEH 1	VEH 2	VEH 3	PED	OTH
			HOME WORK											
			HOME WORK											
			HOME WORK											
			HOME WORK											
			HOME WORK											
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)				ADDRESS		CITY		PHONE					
									HOME WORK					
									HOME WORK					
									HOME WORK					

COMPLETE ALL DETAILS

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

- ... Straight Road
- ... Hillcrest
- ... One Lane
- Mark Damaged Areas
- ... Curve – R or L
- ... Uphill
- ... One and One-Half Lane
- ... Level
- ... Downhill
- ... Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.



LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 <input type="checkbox"/> DAYLIGHT	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	VEHICLE NO. 1 NO. 2	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
2 <input type="checkbox"/> DAWN	<input type="checkbox"/> 1 <input type="checkbox"/> SIGNALS	<input type="checkbox"/> 1 <input type="checkbox"/> ONE WAY	<input type="checkbox"/> 1 <input type="checkbox"/> DEFECTIVE BRAKES	<input type="checkbox"/> 1 <input type="checkbox"/> DRY	2 <input type="checkbox"/> RAINING
3 <input type="checkbox"/> DUSK	<input type="checkbox"/> 2 <input type="checkbox"/> STOP SIGN	<input type="checkbox"/> 2 <input type="checkbox"/> TWO WAY	<input type="checkbox"/> 2 <input type="checkbox"/> DEFECTIVE HEADLIGHTS	<input type="checkbox"/> 2 <input type="checkbox"/> WET	3 <input type="checkbox"/> SNOWING
4 <input type="checkbox"/> DARK STREET LIGHTS ON	<input type="checkbox"/> 3 <input type="checkbox"/> FLASHING RED	<input type="checkbox"/> 3 <input type="checkbox"/> REVERSIBLE ROAD	<input type="checkbox"/> 3 <input type="checkbox"/> DEFECTIVE REAR LIGHTS	<input type="checkbox"/> 3 <input type="checkbox"/> SNOW	4 <input type="checkbox"/> FOG
5 <input type="checkbox"/> DARK STREET LIGHTS OFF	<input type="checkbox"/> 4 <input type="checkbox"/> FLASHING AMBER	<input type="checkbox"/> 4 <input type="checkbox"/> INTER-CHANGE LOOP RAMP	<input type="checkbox"/> 4 <input type="checkbox"/> TIRES WORN	<input type="checkbox"/> 4 <input type="checkbox"/> ICE	5 <input type="checkbox"/> OTHER (SPECIFY)
6 <input type="checkbox"/> DARK NO STREET LIGHT	<input type="checkbox"/> 5 <input type="checkbox"/> RR SIGNAL	<input type="checkbox"/> 5 <input type="checkbox"/> ALLEY	<input type="checkbox"/> 5 <input type="checkbox"/> PUNCTURED OR BLOWN TIRES	<input type="checkbox"/> 5 <input type="checkbox"/> OTHER (SPECIFY)	
7 <input type="checkbox"/> OTHER (SPECIFY)	<input type="checkbox"/> 6 <input type="checkbox"/> OFFICER/FLAGMAN	<input type="checkbox"/> 6 <input type="checkbox"/> TWO WAY-LEFT TURN LANES	<input type="checkbox"/> 6 <input type="checkbox"/> OTHER (SPECIFY)		
	<input type="checkbox"/> 7 <input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1 <input type="checkbox"/> SEPARATED		NAME OF INVESTIGATING POLICE AGENCY: _____ INVESTIGATING AGENCY REPORT NO. _____	
	<input type="checkbox"/> 8 <input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2 <input type="checkbox"/> DIVIDED			
	<input type="checkbox"/> 9 <input type="checkbox"/> OTHER	<input type="checkbox"/> 3 <input type="checkbox"/> UNDIVIDED			

A separate claim form should be submitted for each claimant

This information is being provided to aid in resolving the claim.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

Date and Place (residential address, city and county)