

NOTICE OF TORT CLAIM

OKLAHOMA MUNICIPAL ASSURANCE GROUP (OMAG) – MUNICIPAL LIABILITY PROTECTION PLAN

A. CLAIMANT REPORT

To the CITY OF BETHANY
Public entity you are filing the claim against.

PLEASE PRINT OR TYPE AND SIGN

CLAIMANT(S) _____ CLAIMANT(S) SOCIAL SECURITY NO. _____
ADDRESS _____ CLAIMANT(S) DATE OF BIRTH _____ M ___ F ___
PHONE: HOME () _____ BUS. () _____

- (Exact Date Required) (Continue on another sheet if needed for any information requested)
- DATE AND TIME OF INCIDENT _____ () a.m. () p.m.
 - LOCATION OF INCIDENT _____
 - DESCRIBE INCIDENT _____

4. LIST ALL PERSONS AND/OR PROPERTY FOR WHICH YOU ARE CLAIMING DAMAGES:

BODILY INJURY: WAS CLAIMANT INJURED? YES ___ NO ___ If yes, complete this section
Describe injury _____
WERE YOU ON THE JOB AT THE TIME OF INJURY? YES ___ NO ___ If so, please provide Employer info.

Employer's Name	Address	Phone
		ALL MEDICAL BILLS (attach copies) \$ _____
		LIST OTHER DAMAGES CLAIMED \$ _____

MEDICARE/MEDICAID/SOCIAL SECURITY DISABILITY:
Is there any Social Security Disability involvement ___ Yes ___ No
Has any medical bill been paid or will be paid by Medicare/Medicaid? ___ Yes ___ No. If so, list Medicare/Medicaid Number.
Medicare/Medicaid Number _____
If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y.

Medicare/Medicaid Beneficiary Name (please print) _____ Medicare/Medicaid Beneficiary Name Signature _____

PROPERTY DAMAGE: Proof that you are the owner of the vehicle or property allegedly damaged as specified in your claim will be required.
VEHICLE YEAR _____ MAKE _____ MODEL _____
NOTE: If damage is to a vehicle, a photocopy of your motor vehicle title is required.
IF NOT A VEHICLE, DESCRIBE PROPERTY AND LOSS _____

PROPERTY DAMAGE (Attach repair bills or estimates if available) \$ _____
LIST OTHER DAMAGES CLAIMED \$ _____

5. NAME OF YOUR INSURANCE CO.	POLICY NO.	AMOUNT CLAIMED	AMOUNT RECEIVED
_____	_____	\$ _____	\$ _____

6. The names of any witnesses known to you:

Name	Address	Phone Number
_____	_____	_____
Name	Address	Phone Number
_____	_____	_____

STATE THE EXACT AMOUNT OF COMPENSATION YOU WOULD ACCEPT AS FULL SETTLEMENT ON THIS CLAIM.
TOTAL CLAIM.....\$ _____

SIGNATURE(S) DATE
CONTINUE ON THE BACK

B. THIS SECTION IS FOR USE BY THE PUBLIC ENTITY WHICH RECEIVES THE CLAIM

To inquire about this claim you may write to OMAG Claims Dept. or call 1-800-234-9461

This Notice of Tort Claim was received by _____

(Title) _____, on _____, 20____

For further information on this claim contact _____

(Title) _____, by telephone at (____)_____

The following reports, statements or other documentation, which support our understanding of the facts relating to this claim are attached:

Information for City Owned Vehicle Involved:

Year: _____ Make: _____ Model: _____ Last 4 Vin#: _____ Dept: _____

As a result of this incident, are there damages to the City vehicle? ____ YES ____ NO

If YES, please fill out an **OMAG Auto Loss Notice** to have it repaired.

Persons who have knowledge of the circumstances surrounding this claim are:

Name	Title/Position	Telephone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Submitted by: _____ Date _____, 20____

Title: _____

AFTER THE PUBLIC ENTITY HAS RECEIVED THIS CLAIM, PLEASE PROVIDE INFORMATION REQUESTED ABOVE AND IMMEDIATELY SEND TO:

OMAG Claims Dept.
3650 S. Boulevard
Edmond, OK 73013
Phone (405) 657-1400
Fax (405) 657-1401
claimsdepartment@omag.org