City of Columbus
Claimant Statement Form

Hours of Operation: 8am to 5pm Weekdays

NAME	BIRTH DATE	HOME PHONE	WORK PHONE
STREET ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS	EMPLOYER NAME		

CITY DEPARTMENT THAT WAS INVOLVED:			NAME OF EMPLOYEE (IF KNOWN):	
TYPE OF DAMAGE:	____VEHICLE	____ OTHER PROPERTY	____INJURY	POLICE REPORT MADE? ☐ YES ☐ NO
IF YES, WHAT POLICE DEPT. & REPORT #?		IF NO, WHY?		
INCIDENT DATE	INCIDENT TIME	ADDRESS OF INCIDENT		
DETAILED DESCRIPTION OF INCIDENT				

WITNESS NAME:	PHONE:	ADDRESS:
WITNESS NAME:	PHONE:	ADDRESS:

FOR VEHICLE DAMAGE CLAIMS OR AUTOMOBILE ACCIDENTS

VEHICLE MAKE/MODEL	YEAR	LICENSE PLATE #	MILEAGE
OWNER'S NAME	OWNER'S ADDRESS & PHONE		
DRIVER'S NAME	DRIVER'S ADDRESS & PHONE		
TWO REPAIR ESTIMATES (ATTACH ESTIMATE DOCUMENTS)	(1) $	(2) $	
# OF PEOPLE IN YOUR VEHICLE:	WHO:		
DEDUCTIBLE AMOUNT	AUTO INSURANCE COMPANY	MEDICAL INSURANCE COMPANY	

FOR DAMAGE CLAIMS OTHER THAN VEHICLE DAMAGE

WHAT IS DAMAGED	CAUSE OF DAMAGE & HOW IT WAS DAMAGED
AGE OF DAMAGED PROPERTY:	REPLACEMENT, RESTORATION OR REPAIR COST (IF MORE THAN ONE ITEM, YOU MUST FILL OUT THE ITEMIZED PROPERTY CLAIM FORM):
PROPERTY INSURANCE COMPANY	DEDUCTIBLE AMOUNT

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FOR PERSONAL INJURY CLAIMS

NATURE & EXTENT OF YOUR INJURY

HEALTH INSURANCE COMPANY	DEDUCTIBLE AMOUNT	HOSPITAL TRANSPORTED TO:
ATTENDING PHYSICIAN NAME	ATTENDING PHYSICIAN ADDRESS	
TOTAL MEDICAL EXPENSES TO DATE	AMOUNT PAID BY INSURANCE	AMOUNT PAID OUT OF POCKET

LIST & PROVIDE PROOF OF ANY PHYSICAL DISABILITIES

PROVIDE DATE AND NATURE OF ANY PRIOR INJURIES

The Ohio Revised Code, Section 2744.05 outlines limitations of damages awarded for claims against political subdivisions. If a claimant receives or is entitled to receive benefits from insurance policy or policies, that amount will be deducted from any award the polictial subdivision may condider paying. This includes Medicaid, Medicare and auto policIES. You must file a claim with your insurance company prior to filing a claim with the City of Columbus.

I further state that I am not entitiled to receive additional reimbursement for these injuries and/or damages from any other source other than the City of Columbus and that the claim(s) arising from these injuries and/or damages are a direct result of this incident.

CLAIMANTS SIGNATURE _____ DATE _____

SWORN TO BEFORE ME and subscribed in my presence this _____ day of _____

_____, 20___ .

_____
NOTARY PUBLIC, STATE OF OHIO

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Itemized Property Claim Form

Property Description (Including brand name and serial #)	Quantity	Date purchased or Age	Purchase Price	Replacement, Restoration or Repair cost