

Please read the following entirely before completing the attached claim form. This acknowledges your request for a claim form, which is enclosed. You may otherwise choose to file a claim with your insurance carrier.

Return the completed, signed claim form as soon as possible. Include the date, time, and specific location of the incident, the cause of any injury or damages, and the names and addresses of any witnesses or other interested persons. **Submit with your claim form copies of any photographs, bills, receipts, estimates, police reports (or the report number) and other documents in support of your claim. This information may facilitate faster claim processing.**

If you are claiming automobile damage and your vehicle is drivable, send **two repair estimates in addition to the other documents.** If you are claiming bodily injury, send copies of **all medical bills and reports.**

Once your claim form has been received, an investigator will be assigned to your case. The investigator *may* contact you for further information. Upon completion of the investigation, you will be notified of a decision.

Your claim must be received in writing and either hand delivered, mailed or mailed certified, return receipt requested, within one (1) year of the date of incident. **FACSIMILE TRANSMISSION IS NOT ACCEPTABLE.**

It is necessary that you sign and date the claim form where indicated. Notice of claim forms and/or letters not signed will not be processed.

If you have any questions, you may telephone our claims desk between the hours of 8:30 A.M. and 4:30 P.M. at (410) 396-3308 for automobile liability claims or (410) 396-3400 for general liability claims.



MAYOR AND CITY COUNCIL OF BALTIMORE

STATEMENT OF CLAIM

DEPARTMENT OF LAW
CENTRAL BUREAU OF INVESTIGATION (CBI)
7 E. Redwood Street, 6th Floor, Baltimore MD 21202
410-396-3400 / 410-396-3308

FOR OFFICE USE ONLY

Invest: _____
Date: _____
File #: _____

Claimant's full Name: _____

Address (Include postal zone): _____

Home Phone: _____ Cell: _____ Date of Birth: _____

Exact Location of Incident: _____

Date of incident: _____ Time: _____ am pm

The Incident (describe fully)

Property Damaged (describe fully, including photographs)

Do you have Insurance to cover this loss: Yes No Did you file a claim with your Insurance company regarding this loss? Yes No

Name of Insurance company: _____ Policy Number: _____ Effective Dates: _____ to _____

Estimated Damages: (describe fully)

Witnesses Names and Addresses

1. _____

2. _____

3. _____

IF ANYONE WAS INJURED, FILL IN BELOW

Name of Injured Party: _____ Address: _____

Name of Injuries: _____

Attending Doctor's Name: _____

If Treated at Hospital, Give Name and Address: _____

Occupation: _____ Employer's Name and Address: _____

Time lost from work? Yes No Specify Dates: _____ Salary: Wkly: _____ Hrly: \$ _____

Was Incident Reported?: Yes No To Whom?: _____ When: _____

I do solemnly swear and affirm under penalty or perjury that the above representations are true and correct to the best of my knowledge. I understand that false statements constitute fraud and will be referred to the State's Attorney for prosecution. I further swear and affirm that I have not been indemnified by an Insurance company for the loss (es) that I now claim.

Claimant's Signature: _____ Dated: _____

