NOTICE OF CLAIM

Please PRINT or TYPE info

Please be advised that an incomplete form will be returned, delaying processing.

Forward to:
Ralph J. Marra, Jr., Esq.
Senior Vice President
Chief of Legal & Regulatory Affairs
New Jersey Sports and Exposition Authority
One DeKorte Park Plaza
Lyndhurst, NJ 07071

This form should be submitted regardless of whether any other documentation has been furnished to the Authority. It is required that, pursuant to N.J.S.A. 59:8-6. the within form be completed in full detail. We are also requesting that you return a completed form to this office within 20 days.

1. Claimant:

_____ _____ _____
Last Name First Middle Date of Birth Phone No.

Married ____ Single ____ _____
Spouse's Name

_____ _____
Street /Mailing Address E-Mail

_____ _____
City State ZIP Social Security Number

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, complete question #2

_____ _____
Name Mailing Address

_____ _____
Relationship to Claimant City State ZIP

3. The occurrence of accident which gave rise to this claim occurred on:

a. _____ ***b***._____
Date / Time: City State

c. _____
EXACT location of the occurrence (Stadium / Arena / Racetrack – seating section / parking lot #)

d. ***Describe in detail how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.***

_____

_____

_____

_____

e. State the name(s) of NJSEA employee(s) whom you claim were at fault, including any information that will assist in identifying and locating them.

_____

_____

_____

_____

f. State the negligence or wrongful acts of the NJSEA employee(s) which caused your damages.

_____

_____

_____

_____

g. State the name and address of all witnesses to the accident or occurrence.

_____

_____

_____

_____

h. State the name of all security personnel, police officers and/or police departments who investigated the accident and provide a copy of the incident or investigative report

_____

_____

_____

_____

4.***a. Claim for Damages*** *(check appropriate space):*

_____ Personal Injury _____ Property Damage _____ Other – Explain in detail.

_____

_____

_____

_____

b. If you claim personal injury:

(1) ***Describe your injuries resulting from the accident or occurrence*** _____

_____

_____

_____

_____

(2) ***Do you claim permanent disability resulting from this injury***: _____ Yes ____ No

If yes, describe the injuries believed to be permanent.

_____

_____

_____

_____

(3) ***Were you examined and/or treated by the Meadowlands Medical Department?***

___ Yes ___ No.

(4) ***For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic services, <u>whether or not treatment is completed</u> ("to be provided" is not an acceptable response) state*** *(you may use a separate piece of paper if necessary):.*

Name of hospital, doctors or other facility	Address hospital, doctors or other facility	Dates of treatment or service	Amount of charges to date	Amount paid or payable by other sources, such as insurance

(5) ***Provide employment information <u>whether or not any claim</u> is being made for lost wages or lost time from work*:**

_____	_____
Name of Employer	Address of Employer
_____	_____
Your Occupation	Date you became employed
_____	_____
Rate of pay	Date of absence from work
_____	_____
Total lost wages to date	If still out, expected date of return

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income. If self-employed, a copy of your previous year's income tax records must be submitted.

(6) ***Set forth any and all other losses or damages claimed by you.***

_____

_____

_____

_____

(7) ***If you claim property damage****:*

(a) ***Describe the property damaged****:*

_____

_____

_____

(b) ***The present location and time when the property may be inspected***. _____

_____

(c) ***Date property acquired***: _____

(d) ***Cost of Property***: _____

(e) ***Value of property at time of the accident***: _____

(f) ***Description of damage***: _____

_____

_____

_____

(g) ***Has the damage been repaired***: _____ ***If so, by whom, when and costs of repairs.***

_____

(h) ***Attach an estimate of repair costs to this form. Two estimates required if damage exceeds $750.***

(i) ***Attach photographs of damaged property.***

(j) ***Set forth in detail, the monetary loss claimed by you for property damage.***

_____

_____

_____

_____

(k) ***Set forth in detail all other items of loss or damages claimed by you and the method by which you made calculation.***

_____

_____

_____

_____

(l). ***The total amount of your claim***: _____

8. *a.* ***Have you made a claim against anyone else for the losses or expenses claimed in this notice****?* _____ Yes _____ No

If yes, set forth the name and address of all persons and insurance companies against whom you have made such claims:

_____

_____

_____

_____

b. ***Have you applied for or do you receive, any benefits from any Municipal, State or Federal agency?*** _____ Yes _____ No

If so, state what agency: _____

9. ***Are any of the losses or expenses claimed herein covered by any policy of insurance? _____ For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.***

_____

_____

_____

10. ***Have you received or agreed to receive any money from anyone for the damages claimed therein?*** _____

If so, set for the details of such agreement: _____

_____

_____

_____

11. ***The following items must be submitted with this notice ("to be provided" is not an acceptable response*****):**

(1) Copies of itemized bills for each medical expense and other losses and expenses claimed.

(2) Full copies of all appraisals and estimates of property damages claimed by you.

(3) Copies of all written reports of all expert witnesses and treating physicians.

(4) A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

12. ***Prior claims***.

Have you ever made a claim before against the NJSEA or anyone else? _____ Yes _____No

If so, list date of accident, location, parties involved, insurance carrier and claim number:

_____

_____

_____

_____

Have you made or presented any claim or request for remuneration, whether a lawsuit, workers compensation matter or insurance/liability claim?

_____

_____

_____

_____

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by the law.

Dated: _____ _____

Claimant or person filing

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals, medical facilities and employers to release to NJSEA any and all records, reports, and other information concerning the treatment and/or employment of the claimant, herein named. This authorization shall remain in effect until my claim against NJSEA has been resolved.

The claimant will agree to execute and promptly return any required forms or authorizations needed by hospitals or providers to release information, including the full name and address of the provider being set forth in such an authorization by the claimant.

Dated: _____

X_____
(Signature)

_____
Print your name

(This must be signed by claimant or the parent/guardian of claimant
who is a minor or by legal representative)

Please Print Claimant's Name: _____

Date of Occurrence: _____

MEDICAL DEPARTMENT
50 Route 120
East Rutherford, NJ 07073
201- 460- 4111

Date: _____ Office use only: _____

Patient's Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Incident: _____ ETR#: _____

Permission to Release Medical Records

I hereby give the NJSEA's medical records keeper permission to release my medical record(s) from (date): _____ and forwarding same to me and to forward same to NJSEA insurance company, if they request same.

_____
Patient's or Guardian's Signature

After the medical record keeper at the NJSEA receives this signed permission form, your medical record will be forwarded to you.

Thank you,

Fran Guthrie, RN /s/
Medical Services Manager

A request for a medical report is not sufficient Notice of Claim against the New Jersey Sports and Exposition Authority. To make a claim, the Notice of Claim form is available on the NJSEA website.