ALAMEDA-CONTRA COSTA TRANSIT DISTRICT

CLAIM FOR DAMAGES

(Government Code § 910 and following)

INSTRUCTIONS

- **Claims may be barred if not filed within the time limits under the California Government Code.**
- **Answer all items fully to the best of your knowledge and information.**
- **Attach separate sheets as necessary to provide full details – SIGN EACH SHEET.**
- **Fill out in duplicate. ONE COPY TO BE RETAINED BY CLAIMANT.**
- **Provide self-addressed stamped envelope for return of copy of claim.**
- **AC Transit cannot give you any legal advice.**
- **Claims sent by fax or email will not be accepted as valid claims.**

PLEASE FILE CLAIM WITH: AC Transit Office of the District Secretary
1600 Franklin Street
Oakland, CA 94612

Reserved for Filing Stamp
File No.

☐ **INITIAL CLAIM** ☐ **AMENDED CLAIM**

1. Claimant's Full Name: _____ **Date of Birth:** _____ **Daytime Phone:** _____

2. Claimant's Home Address: _____
Number Street Apt. No. City State Zip Code

3. Mailing Address if Different: _____
Number Street Apt. No. City State Zip Code

4. Claimant's Social Security Number: _____ **Home Phone:** _____ **Occupation:** _____

5. Is Claimant covered by Medicare? ☐ **Yes** ☐ **No If Yes, Medicare Number:** _____

6. Is Claimant covered by Medi-Cal? ☐ **Yes** ☐ **No If Yes, Medi-Cal Number:** _____

7. Date of Incident: _____ **Day of Week:** _____ **Time of Incident:** _____ ☐ **A.M.** ☐ **P.M**
Month/Day/Year

8. Location of Incident: _____
Please be as exact as possible and include street name, nearest cross street, or address and city where incident took place.

9. Bus No: _____ **Route No.** _____ **Direction of Travel:** _____ **Driver's Badge No.** _____

10. Was claimant: ☐ **A passenger in a District vehicle?** ☐ **A pedestrian?** ☐ **The driver of another vehicle?**
☐ **A passenger in another vehicle?** ☐ **The owner of the other vehicle or property? If not, who was:** _____

11. Describe the incident which resulted in this claim being made:

_____

_____

_____

12. Describe all injuries/damages caused by this incident:

_____

_____

_____

13. List the names and addresses of all doctors, hospitals, and healthcare providers who treated the claimant for injuries described in item number 10:

_____

_____

_____

_____

SEE REVERSE SIDE TO COMPLETE

14. Did any previous medical problem affect the same areas of the claimant's body that were injured in this incident? ☐ **Yes** ☐ **No**
If yes, please explain.

_____

_____

15. If the total amount claimed is less than $10,000, enter the amount claimed here: _____

Is the amount claimed more than $25,000? ☐ **Yes** ☐ **No**

16. How were the claimant's damages determined? (Please include copies of all receipts and/or bills)

_____

_____

_____

17. If the claimant was the owner of a vehicle involved in this incident, please attach copies of the following:

a) Two (2) detailed estimates for auto repair **b) Current registration and/or proof of ownership** **c) Proof of Insurance**

18. What did the District or its employee do, or fail to do, that caused this damage or injury:

_____

_____

_____

19. List the name(s) of the District employee(s) who caused this damage or injury, if known. If the name and badge number(s) are not known, please provide a detailed physical description.

_____

_____

20. List the name, address and telephone number of all witnesses to this incident:

_____

_____

_____

21. Please provide any additional information you believe might be helpful to the District in considering this claim:

_____

_____

22. All noticed and communications with regard to this claim will be directed to the Claimant listed in lines 1 and 2 on the other side of this form, unless you complete the following to identify to whom further communications should be directed:

Name: _____ **Relationship:** _____

Address: _____ **State:** _____ **Zip** _____

Daytime Phone: _____ **Home Phone:** _____

_____	_____	_____
Claimant's Printed Name	**Claimant's Signature**	**Date Signed**

(Note: If the claim by someone on behalf of the claimant, the person making the claim on behalf of the claimant must sign below.)

_____	_____	_____
Printed Name of Person acting on behalf of the Claimant	Signature of Person acting on behalf of the Claimant	Date Signed

WARNING: PRESENTATION FOR ALLOWANCE OR PAYMENT OF A FALSE OR FRAUDULENT CLAIM, WITH INTENT TO DEFRAUD, IS A CRIME PUNISHABLE UNDER CALIFORNIA PENAL CODE, SECTION 72.