

CLAIM REPORT AND DEMAND

This claim MUST be filled out by the person making the claim against the State and/or its employees. It is to be returned within 10 DAYS to:

**Human Resources
MSUM MOORHEAD
1104 7th Ave South
Moorhead, MN 56563**

1. CLAIMANT

Name of Claimant

Home Address

Date of Birth

City, State, Zip Code

Marital Status

Home Phone

Name of Spouse

Name of Employer

Address of Spouse

Business Address

No. & Age of Dependents

Business Phone

2. ACCIDENT OR OCCURRENCE

_____ () a.m. () p.m.
Date **Time**

Location

City, State

Weather Conditions

Describe the accident or occurrence in detail : _____

Full names and addresses of all witnesses:

1. _____

2. _____

3. _____

4. _____

5. _____

Full name and address of each state agency and each state employee whom you claim caused your damages or injuries.

1. _____

2. _____

3. _____

4. _____

Full name and address of all other persons, companies, or governmental agencies whom you claim are responsible for your damages or injuries:

1. _____

2. _____

3. _____

4. _____

State the cause of the accident or occurrence: _____

3. DAMAGES OR INJURIES

Full name and address of injured person on whose behalf claim is here made (hereinafter “the injured”):

(If a minor, include birthdate and parents’ names)

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Full name and address of other person(s) suffering injuries, if any:

1. _____

2. _____

3. _____

Describe the injury, damages and losses incurred by the injured on whose behalf claim is made:

What was the injured doing at the time of the accident?

If injury or damage was to property, state in detail the following:

a. What was damaged? _____

b. Name of manufacturer _____

c. How old was it? _____

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d. What condition was it in at the time of accident or occurrence? _____

e. Any prior damage? () yes () no If yes, explain _____

f. Where was it purchased? _____

g. If other than claimant, who owned it at the time of the accident/occurrence? _____

h. Any liens, mortgages, attachments, security interests or other third party rights or claims outstanding on said property? () yes () no

If yes, state name and address _____

i. Estimates cost of repair _____

j. Where is the damaged property now located? _____

If injury or damages were to the person of the injured, state the following:

1. Where was the injured taken? _____

2. Full name and address of doctor first called or seen _____

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3. Full name (s) and addresses of any other doctor (s) giving treatment or diagnosis: _____

4. Did injury arise out of or in the course of the injured's employment? () yes () no

If yes, describe _____

Any type of insurance coverage protecting claimant for the damages sustained? () yes () no

If so, describe kind of coverage and company: _____

State the amount hereby claimed and demanded by you from the State: _____

State the basis for the calculation of this amount?

Have you made any other claims against the State and/or its employees? () yes () no

If yes, state the date(s) and circumstances: _____

I hereby certify that the foregoing statements and claim made by me are true. I am aware that if any statement made herein is to my knowledge false, in whole or in part, that I am subject to punishment provided by law.

Signature of Claimant

Date