NOTICE OF TORT CLAIM

GENERAL INSTRUCTIONS:

Pursuant to the New Jersey Tort Claims Act, this Notice of Claim form has been adopted as the official form for filing claims against the County of Ocean and its agents and employees.

The questions are to be answered to the extent of all information available to the Claimant or to his or her attorneys, agents, servants, and employees, under oath. The fully completed Notice of Tort Claim Form and the documents requested shall be returned by hand-delivery, certified and/or regular mail to:

Physical Address:
County of Ocean
Risk Management Division
101 Hooper Avenue
Toms River, New Jersey 08753-2191

Post Office Box
County of Ocean
Risk Management Division
P.O. Box 2191
Toms River, New Jersey 08754-2191

NOTE CAREFULLY: Your claim will not be considered filed as required by the New Jersey Tort Claims Act until this completed form has been filed with the County of Ocean. Failure to provide the information requested, including such responses as "to be provided" or "Under Investigation" will result in the claim being treated as not being properly filed. **If the tort claim involves an allegation of personal injury, the HIPAA-Compliant Authorization for release of hospital, medical, insurance, and pharmacy records must be completed.**

Timely Notice of Claim must be filed within ninety (90) days after the incident giving rise to the claim.

This form is designed as a general form for use with respect to all claims. Some of the questions may not be applicable to your particular claim. For example, if your claim does not arise out of an automobile accident, questions regarding road conditions might not be applicable. In that event, please indicate, “Not Applicable”.

If you are unable to answer any question because of a lack of information available to you, specify the reason the information is not available to you. If a question asks that you identify a document, it will be sufficient to furnish a true and legible copy. Where a question asks that you “identify all persons,” provide the name, address and telephone number of the person.

If you need more space to provide a full answer, attach supplementary pages, identifying the continuation of the answer with the number to the applicable question.

Please be aware that all sources of primary insurance coverage must be exhausted before the County of Ocean is obligated to consider your claim.

DEFINITIONS:

"Claimant" shall refer to the person or persons on whose behalf the Notice of Claim has been filed with the County.

"Documents" shall refer to any written, photographic, or electronic representation, and any copy thereof, including, but not limited to, computer tapes and/or disks, videotapes and other material relating to the subject matter of the claim.

"HIPAA" - the federal *Health Insurance Portability and Accountability Act* - provides protections for patients' privacy rights.

"Person" shall include in its meaning a partnership, joint venture, corporation, association, trust or any other kind of entity, as well as a natural person.

"Public Entity" shall refer to the County of Ocean along with any agent, official, or employee of the County of Ocean against whom a claim is asserted by the Claimant.

PRESERVATION AND MAINTENANCE OF SOCIAL MEDIA: In all claims, other than those claims solely seeking reimbursement for damage to property, the County hereby requests the Claimant preserve and maintain and shall not destroy, delete, alter, modify or "misplace" any evidence, tangible papers, reports, status updates, wall posts, tweets, blogs, photographs, objects, websites, or other information contained in social networking site accounts, including, but not limited to: Facebook, Twitter, Instagram, TikTok, LinkedIn accounts. Websites or the like from the date of the incident or occurrence identified in the Notice of Claim through and including any potential trial of this matter.

NOTE: That the questions are divided into sections relating to the claimant, the claim, property damage, personal injury and the basis for the claim against the public entity or public employee. If the claim involves only property damage, the portion on personal injuries need not be answered. If the claim involves no property damage, then the portion on property damage need not be answered.

FURTHER NOTE: Proper service of a Summons and Complaint upon the County of Ocean shall be served upon the **Clerk of the Board of Commissioners, County of Ocean, 101 Hooper Avenue, Toms River, New Jersey 08753**. Service of a Summons and Complaint upon the "Ocean County Clerk", 118 Washington Street, Toms River, New Jersey is not proper service upon the County of Ocean.

County of Ocean

Division of Risk Management

PO Box 2191
Toms River, NJ 08754-2191
(732) 929-2109 / Fax (732) 506-5006

NOTICE OF CLAIM FOR DAMAGES

NOTICE: This form has been adopted by the County of Ocean pursuant to NJSA 59:8-6. It is not a supplemental form. It is in lieu of the statutory Notice prescribed by NJSA 59:8-4 and is the only form of Notice accepted by the County of Ocean.

FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT

1. Claimant:

_____ _____/_____/_____
Last Name, First, Middle — Date of Birth

_____ _____
Street Address — Social Security Number

_____
City, State, Zip Code

_____
Mailing Address, if different than Street Address

Married ( ) Single ( ) Spouse's Name:_____

Identify each person residing with the Claimant and the relationship, if any, of the person to the Claimant

_____
_____
_____
_____

Provide all addresses of the Claimant for the last 10 years, the dates of the residence, the persons residing at the addresses at the same time as the Claimant resided at the address and the relation, of any of the persons to the Claimant.

_____
_____
_____
_____

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

_____
Name

_____
Mailing Address

_____
City, State, Zip Code

Relationship to Claimant: Attorney at Law ( ) or_____
Explain Relationship

2. The occurrence or accident which gave rise to this claim occurred:

   (a) Date_____ Time:_____

   Weather Conditions_____

   (b) Identify the location or place of the accident or occurrence:

   _____ _____
   Municipality Street Address and Exact Location of Occurrence

   (c.) Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form:

   _____
   _____
   _____

   (d.) State the name and address of the of any and all public entities or public employees, other than the County of Ocean or its employees, which you claim caused your damage:

   _____
   _____

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

_____
_____

(f.) State in detail the negligence or wrongful acts of the County of Ocean and/or each County Employee which caused your damages:

_____
_____
_____

(g.) List any and all individuals who were witnesses to or who have knowledge of the facts of the accident or occurrence that give rise to the claim. Provide the full name and address of each individual:

_____
_____
_____
_____
_____

(h.) State the names of all police officers and police departments who investigated the accident:

_____
_____
_____
_____
_____
_____

(I.) If you claim that the injury or property damage was caused by a dangerous condition of property under the control of the County of Ocean, specify the nature of the alleged dangerous condition, and the manner in which you claim the condition cause the injury.

_____
_____
_____
_____
_____
_____

(J.) If you allege a dangerous condition of public property, state the specific basis on which you claim that the County of Ocean was responsible for the condition and the specific basis and date on which you claim that the County of Ocean was given notice of the alleged dangerous condition. Statements such as "should have known" and "Common knowledge" are insufficient.

_____
_____
_____
_____
_____
_____

(k) If you or any other party or witness consumed any alcoholic beverages, drugs or medications within twelve hours before the incident forming the basis of the Claim, identify the person consuming the same and for each person (a) what was consumed, (b) the quantity thereof, (c) where consumed, (d) the names and addresses of all persons present.

_____
_____
_____
_____
_____
_____

3. (A.) Claim for damages: (Check appropriate block)

( ) Personal Injury ( ) Property Damage

( ) Other-Explain in Detail_____
_____

(B). If you claim personal injury:

[1.] Describe in detail the nature, extent and duration of any and injuries resulting from this accident or occurrence

_____
_____
_____
_____
_____
_____

[2.] Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe in detail any injury or condition claimed to be permanent:

_____
_____
_____

[3.] For each hospital, doctor, or other practitioner rendering treatment, examination or diagnostic services, state:

Amount paid: _____ Or:

Name & Address of Hospital, Doctor or Facility	Dates of Treatment or Service	Amount of Charges to date	Payable by other sources such as insurance

[4.] If x-rays were taken, state (a) the address of the place where each was taken, (b) the name and address of the person who took them, (c) the date when each was taken, (d) what each disclosed, (e) where and in whose possession they now are. Include all x-rays, whether prior to or subsequent to the alleged injury forming the basis of the claim.

_____
_____
_____
_____

[5.] If you have any physical impairment which you allege is caused by the injury forming the basis of your claim and which is affecting your ordinary movement, hearing or sight, state in detail, the nature and extent of the impairment and what corrective appliances, support or device you use to overcome or alleviate the impairment.

_____
_____
_____
_____
_____
_____

[6.] If you claim that a previous injury has been aggravated or exacerbated, describe the injury and give the name and present address of each doctor who treated you for the condition, the period during which treatment was received and the cause of the previous injury. Specifically list any impairment, including use of eyeglasses, hearing aid or similar device, which existed at the time of the injury forming the basis of the claim.

_____
_____
_____
_____
_____
_____

[7] If any treatments, operations or other form of surgery in the future has been recommended to alleviate any injury or condition resulting from the incident which forms the basis of the claim, state in detail:

(a) the nature and extent of the treatment, operation, or surgery

(b) the purpose thereof and the results anticipated or expected,

(c) the name and address of the doctor who recommended the treatments, operations or surgery

(d) the name and address of doctor who will administer or perform the same

(e) the estimated medical expenses to be incurred,

(f) the estimated length of time of treatments, operation or surgery, period of hospitalization and period of convalescence,

(g) all other losses or expenditure anticipated as a result of the treatment, operations or surgery,

(h) further if it is your intention to undergo the treatments, operation or surgery, please give an approximate date.

_____
_____
_____
_____
_____
_____

[8] Itemize any and all expenses incurred for hospital, doctors, nurses, x-rays, medicines, care and appliances and indicate which expenses were paid by any insurance coverage.

_____
_____
_____
_____
_____
_____

[9.] If you claim loss of wages or income, as a result of the injury/occurrence, state:

_____	_____
Name of Employer	Address of Employer
_____	_____
Your Occupation	Date You Became Employed
_____	_____
Rate of Pay	Dates of Absence From Work
_____	_____
Total Lost Wages To Date	If Still Out, Expected Date Of Return To Work

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.

[10.] If other loss of income, profit or earnings is claimed, state
(a) total amount of loss,
(b) give a complete detailed computation of the loss,
(c) the nature and dates of the loss

_____
_____
_____
_____
_____
_____

(C.) If you claim property damage:

[1.] Describe the property damage: _____
_____
_____

[2.] The present location and time when the property may be inspected:
_____
_____

[3.] Date property acquired: _____

[4.] Cost of property:_____

[5.] Value of property at time of accident/occurrence:_____

[6.] Description of damage: _____
_____

[7.] Has the damage been repaired? _____ If so, by whom, when and cost of repairs: _____
_____

[8.] Attach each estimate of repair costs to this form.

[9] Attach photographs of the damaged property.

[10.] Set forth in detail, the monetary loss claimed by you for property damage:_____
_____
_____
_____

(d.) Set forth in detail, all other items of loss or damages claimed by you and the method by which you made the
calculation:_____
_____
_____

(e.) The amount of the claim:
_____

4. Have you made a claim against anyone else for any of 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:

_____
_____
_____
_____

5. Are any of the losses or expenses claimed herein covered by any policy of insurance?

( ) yes ( ) no

If yes, for each such policy, state the name and address of the insurance company, policy number and benefits paid or payable:

_____
_____
_____
_____

6. If this claim involves an automobile, please state:

(a.) The name of the insurance company covering the automobile:_____

(b.) The name of your local agent:_____

(c.) Your policy number and dates of coverage (if other than automobile)_____
_____

(d.) State the name of your homeowner's, rental, or property insurance company:_____
_____

(e.) The name of your local insurance agent: _____

(f.) Your policy number:_____

7. If you have any other form or kind of liability insurance, please state:

(a.) The name or names of the insurance company: _____
_____

(b.) Type of liability coverage:_____

(c.) The name of your local agent: _____

(d.) The policy number or numbers:_____

8. Have you received, or agreed to receive, any money from anyone for the damages claimed herein?

   ( ) yes ( ) no

   If yes, set forth the details of such agreement:

   _____
   _____
   _____
   _____
   _____

9. If you or any of the parties to this action or any of the witnesses made any statements or admissions, set forth what was said; by whom said; the date and place where said; and in who presence, giving names and addresses of any persons having knowledge thereof.

   _____
   _____
   _____
   _____
   _____

10. If any photographs, sketches, charts, or maps were made with respect to anything which is the subject matter of the Claim, state the date thereof, the names and addresses of the persons making the maps and of the persons who have present possession thereof. Attach copies of any photographs, sketched, charts or maps.

    _____
    _____
    _____
    _____

11. State the total amount of your claim and the basis on which you calculated the amount claimed.

    _____
    _____
    _____
    _____

12. Please specify, if known, whether the claim arises out of any of the following activities:

    (a.) Any construction project: _____

    (b.) Any demolition project: _____

    (c.) Any road or bridge project: _____

    (d.) Other:_____

13. State whether the incident has occurred on any sidewalk, street, or bridge located in:

_____
_____
_____

14. If yes, please give exact location:

_____
_____
_____

15. The following items must be submitted with this notice:

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

(b.) Full copies of all appraisals and estimates of property damage claimed by you.

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

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

I hereby certify that the forgoing statements are 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 is willfully false, that I am subject to punishment provided by law.

Date:_____ Signature: _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HOSPITAL, MEDICAL, INSURANCE, AND PHARMACY RECORDS PURSUANT TO 45 CFR 164.508

Claimant/Patient's Name: _____

Date of Birth: _____ Social Security No. _____/_____/_____

Claimant/Patient's Current Address:

_____

_____

_____

TO: _____
[Name of Healthcare Provider, Physician, facility]

_____

_____

_____

I hereby authorize the designated records custodian of the HIPAA covered individual or entity identified above to disclose all protected health information for review and evaluation in connection with a legal claim. I expressly request that you disclose, make available and furnish to the attorneys, claims adjusters, investigators, or agents of the County of Ocean full and complete copies of all records and reports regarding my medical condition and/or treatment spanning the time period of [date of birth] to present. This information includes but is not limited to medical records, copies of films (x-rays, photographs, photographic slides or otherwise) pathology slides, diagnostic reports and laboratory testing reports. No originals will be released. No pathology material will be release by you must notice the above attorneys, claims adjusters, investigators, or agents of the County of Ocean as to the existence of such pathology material.

This protected health information is disclosed for the following purposes: My notice of claim filed against the County of Ocean and/or their agents or employees pursuant to N.J.S.A. 59:8-1 et seq.

I acknowledge that I have the right to revoke this authorization, in writing, by sending written notification to you at the above-referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to no longer be protected under 45 CFR 164.508.

I understand that the covered entity to which this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect and amend my medical records as provided in 45 CFR 164.526. I have the right to an

accounting of the use and disclosure of my health information to any third party as provided in CFR 164.528.

This will further authorize you to provide updated medical records for the undersigned to the above individuals, firms and corporations through the expiration date for this authorization without additional authorization. A facsimile, copy or photocopy of this authorization shall authorize you to release the records herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Dated this ____ day of _____, 20____

_____
Signature of Claimant or Personal Representative

_____
Print or Type Name of Claimant or Personal Representative

_____
Description of Personal Representative's Authority to Sign for Claimant (Attach documents which show authority)

STATE OF NEW JERSEY

COUNTY OF _____

SUBSCRIBED and sworn to before me this _____ day of _____, 20___

_____
Notary Public
My Commission expires: