

**Notice of Claim Instructions-Long Form  
(Property Damage and Personal Injury)**

If you wish to make a claim against the State of New Jersey, please read the following information.

The State of New Jersey is protected from Tort actions by State Statute, N.J.S.A. 59:1-1, et Seq., and more specifically, Chapter 9, Paragraph 2e. Simply stated, Title 59: 9-2e means that, if you have insurance to cover "physical damage" to your property, the money you are entitled to receive under such policy of insurance shall be deducted from your claim against the State.

To expedite the handling of your claim, we ask that you settle your physical damage with your physical damage insurance carrier. You may submit a claim for your deductible by forwarding a copy of your estimate of repair and a copy of your declaration sheet showing the amount of your physical damage deductible to the address listed below. If you do not have "physical damage" coverage and wish to submit a claim, please forward two estimates and a copy of the declaration sheet on your insurance policy, and complete the enclosed Tort claim form. Moreover, if the damage has been repaired, you may submit a copy of the receipt of repair.

Please indicate if you have one or both of the following supplemental plans:

Auto Club: Submit information regarding motor or auto club insurance for towing and labor benefits, if available.

Tire Warranty: Advise if there was a tire warranty reimbursement for road defects available.

Since all claims which are filed against the State of New Jersey must be filed within 90 days of their occurrence, we suggest that your documentation be sent via certified mail. Although this is not required, it will ensure that you have proof of receipt by this office.

Please allow a minimum of 90 days for a reply to your claim submittals.

Please mail your submittals to:

**Department of the Treasury  
Division of Risk Management  
P.O. Box 620  
Trenton, NJ 08625-0620  
Attn: Tort Claims Unit**

**INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY**

**FORWARD TO: DEPARTMENT OF THE TREASURY  
DIVISION OF RISK MANAGEMENT  
20 WEST STATE STREET, PO BOX 620  
TRENTON, NEW JERSEY 08625-0620  
PHONE: (609) 292-4347**

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

**1.** \_\_\_\_\_  
**NAME OF CLAIMANT** (MR. OR MRS.) CIRCLE ONE **STREET ADDRESS**

\_\_\_\_\_  
**DATE OF BIRTH** **CITY** **STATE** **ZIP CODE**

\_\_\_\_\_  
**DAYTIME PHONE NUMBER** **SOCIAL SECURITY NUMBER**

**2. IF NOTICES AND CORRESPONDENCE IN CONNECTION WITH THIS CLAIM ARE TO BE SENT TO A PERSON OTHER THAN CLAIMANT, COMPLETE ITEM #2.**

\_\_\_\_\_  
**NAME OF PERSON** **STREET ADDRESS**

\_\_\_\_\_  
**TELEPHONE NUMBER** **CITY** **STATE** **ZIP CODE**

**RELATIONSHIP TO CLAIMANT:**  **ATTORNEY**  **OTHER** \_\_\_\_\_  
(SPECIFY)

**3A. CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:**

\_\_\_\_\_  
**DATE AND TIME** **LOCATION (MILEPOST, NEAREST EXIT, CROSS STREET)**

\_\_\_\_\_  
**STATE VEHICLE DRIVER'S NAME** **CITY** **STATE**

\_\_\_\_\_  
**STATE PLATE # AND VEHICLE DESCRIPTION**

**3B. DESCRIBE THE ACCIDENT OR OCCURRENCE: IF A DIAGRAM WILL ASSIST YOUR EXPLANATION, USE A SEPARATE SHEET AND ATTACH IT TO THIS FORM.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3C. STATE THE NAME AND ADDRESS OF THE STATE AGENCY OR AGENCIES THAT YOU CLAIM CAUSED YOUR DAMAGE.**

---

---

---

**STATE THE NAMES OF STATE EMPLOYEES WHOM YOU CLAIM WERE AT FAULT, INCLUDING ANY INFORMATION THAT WILL ASSIST IN IDENTIFYING AND LOCATING THEM.**

---

---

---

**3D. STATE THE NEGLIGENCE OR WRONGFUL ACTS OF THE STATE AGENCY AND STATE EMPLOYEES WHICH CAUSED YOUR DAMAGES.**

---

---

---

**3E. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO THE ACCIDENT OR OCCURRENCE.**

---

---

---

**3F. STATE THE NAMES OF ALL POLICE OFFICERS AND POLICE DEPARTMENTS WHO INVESTIGATED THIS ACCIDENT. PROVIDE POLICE REPORT CASE NUMBER, IF AVAILABLE.**

---

---

---

**4A. CLAIM FOR DAMAGES (CHECK APPROPRIATE BLOCK):**

PERSONAL INJURY

PROPERTY DAMAGE

OTHER-EXPLAIN \_\_\_\_\_

**4B. IF YOU CLAIM PERSONAL INJURY:**

**(1) DESCRIBE YOUR INJURIES RESULTING FROM THIS 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) FOR EACH HOSPITAL, DOCTOR OR OTHER PRACTITIONER RENDERING TREATMENT, EXAMINATION OR DIAGNOSTIC SERVICES, STATE:**

NAME OF HOSPITAL, DOCTOR OR OTHER FACILITY	ADDRESS	DATES OF TREATMENT OR SERVICE	AMOUNT OF CHARGE TO DATE	AMT. PAID OR PAYABLE BY OTHER SOURCE, I.E. INSURANCE

**(4) IF YOU CLAIM LOSS OF WAGE OR INCOME AS A RESULT OF THE INJURY STATE:**

\_\_\_\_\_  
NAME OF EMPLOYER

\_\_\_\_\_  
ADDRESS OF EMPLOYER

\_\_\_\_\_  
YOUR OCCUPATION

\_\_\_\_\_  
DATE YOU BECAME EMPLOYED

\_\_\_\_\_  
RATE OF PAY

\_\_\_\_\_  
DATE OF ABSENCE FROM WORK

\_\_\_\_\_  
TOTAL LOSS WAGES TO DATE

\_\_\_\_\_  
IF STILL OUT, EXPECTED DATE OF RETURN

**NOTE: IF YOUR CLAIMED LOSS OF INCOME ARISES FROM SELF-EMPLOYMENT OR OTHER THAN WAGE, ATTACH A CALCULATION SHOWING THE BASIS OF YOUR CALCULATION OF LOST INCOME.**

**(5) SET FORTH ANY AND ALL OTHER LOSSES OR DAMAGE CLAIMED BY YOU.**

---

---

**4C. IF YOU CLAIM PROPERTY DAMAGE:**

**(1) DESCRIBE THE PROPERTY DAMAGED.**

---

---

---

**(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 \$** \_\_\_\_\_

**(6) DESCRIPTION OF DAMAGE.**

---

---

**(7) HAS THE DAMAGE BEEN REPAIRED?  YES  NO IF SO, BY WHOM, WHEN AND COST OF REPAIRS.**

---

---

**(8) ATTACH EACH ESTIMATE OF REPAIR COSTS TO THIS FORM.**

**(9) SET FORTH IN DETAIL THE LOSS CLAIMED BY YOU FOR PROPERTY DAMAGE.**

**4D. SET FORTH IN DETAIL ALL OTHER ITEMS OF LOSS OR DAMAGES CLAIMED BY YOU AND THE METHOD BY WHICH YOU MADE THE CALCULATION.**

---

---

5. THE AMOUNT OF THE CLAIM \$ \_\_\_\_\_

6. 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:

7. ARE ANY OF THE LOSSES OR EXPENSES CLAIMED HEREIN COVERED BY ANY POLICY OF INSURANCE?     YES     NO

FOR EACH SUCH POLICY, STATE THE NAME AND ADDRESS OF THE INSURANCE COMPANY, POLICY NUMBER AND BENEFITS PAID OR PAYABLE.

\_\_\_\_\_

\_\_\_\_\_

8. HAVE YOU RECEIVED OR AGREED TO RECEIVE ANY MONEY FROM ANYONE FOR THE DAMAGES CLAIMED HEREIN?     YES     NO

IF YES, SET FORTH THE DETAIL OF SUCH AGREEMENT.

\_\_\_\_\_

\_\_\_\_\_

9. THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS NOTICE:

- (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 DAMAGE 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.

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 LAW.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT