Risk Management Office, Office 860
300 Monroe Avenue NW, Grand Rapids, MI 49503
Phone (616)-456-4670
Fax (616) 456-3520

Personal Injury Claim Form

Name_____ Employer_____

Address_____ City/State_____ Zip Code_____

Email_____ Phone (1) _____ Phone (2)_____

Date of Birth_____ Best Way to Contact You (Phone or Email)_____

Date of Incident: _____ Exact Location of Incident:_____

Describe the Incident in Detail (Attach Separate Sheet if Needed):_____

Any Witnesses? (Include Name and Contact Info) _____

Did you contact the Police (Police Report Number) or any City Department(s):

*Identify Department/Contact Person/Date*_____

Damages-Specifically list the damages (Describe medical treatment sought)

What costs or bills incurred?_____

AS PART OF THE CLAIMS PROCESS, YOU MUST CONTACT YOUR INSURANCE COMPANY TO VERIFY ANY COVERAGE

Name of your insurance company and agent:_____

Please state the total amount you are claiming from the City: $_____

I hereby swear that the above information is true under penalty of law.

Before you Sign, Did you Include? PHOTOS MEDICAL BILLS/TREATMENT INSURANCE POLICY POLICE REPORT (If Applicable)

Date:_____ Signed:_____

City Use Only Below

Departments Involved:_____ Amount $_____

Action Taken: APPROVE_____ DENIED_____ CLOSED_____

Reason_____

City Attorney Signature/Date_____ Risk Manager Signature/Date_____