

FORM B

CITY OF DINUBA

CLAIM FORM

Claim Against _____ (Name of Entity)

Claimant's Name _____

Claimant's DOB _____ Claimant's SS# _____

Claimant's Address: _____

Address where Notices related to this Claim shall be sent, if different from above:

Date of incident/accident: _____ Date injury/ damage/ loss discovered: _____

Location of incident/accident: _____

What did entity or employee do to cause this loss, damage, or injury?

(Use the back of this form or separate sheet if necessary to answer this question in detail.)

Names of the Entity's employees who caused this injury, damage, or loss (if known): _____

What are Claimant's specific injuries, damages, or losses? _____

What amount of money is claimant seeking, or if the amount is in excess of \$10,000, which is the appropriate court of jurisdiction? **Note:** If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)]

How was this amount calculated (please itemize)? _____

Date Signed: _____ Signature: _____

If signed by a representative:

Representative's Name _____ Phone # _____

Address _____

Relationship to Claimant _____

PLEASE READ – IMPORTANT!

Your claim must be filed within 6 months of the incident (Government code 911.2).

Your claim will be forwarded to the City's Risk Manager for investigation. Following that, your claim will be either settled or denied. You will be notified by mail.

If your claim is denied, you will have 6 months from date of denial to initiate an action against the city (Government code 945.6). Our hope is that you will be treated fairly. If you have any questions, please call (559) 591-5900 ext. 108.