



# AUTO LIABILITY

## CLAIM AGAINST THE CITY OF PORTLAND

\* for auto accidents involving a City vehicle \*



File Number: \_\_\_\_\_

A claim must be filed with **City of Portland Risk Management** within 180 days after the occurrence of the incident or event.

Normal business hours: Monday through Friday, 8:00am to 5:00pm. Closed on official holidays.

Claims received during regular business hours will be recorded on the date received.

Faxed or emailed claims received after business hours will be recorded on the next working day.

**Please be sure your claim is against the City of Portland, not another public entity.**

Where space is insufficient, please use additional paper and identify information by section number and letter.

Completed forms may be mailed, emailed, faxed, or hand-delivered to:

Risk Management/Liability, 1120 S.W. Fifth, Room 709, Portland, OR 97204-1912, Ph: 503-823-5101, Fax: 503-823-6120  
LiabilityClaims@portlandoregon.gov

**1. Claimant** (Circle: Mr. Mrs. Ms. Miss) \_\_\_\_\_ Date of Birth \_\_\_\_\_

a. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

b. Home Phone \_\_\_\_\_ Business Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

c. Occupation \_\_\_\_\_ d. Marital Status: Single ( ) Married ( ) Divorced / Widowed ( )

If married, name of spouse \_\_\_\_\_

d. E-mail address \_\_\_\_\_

**2. If claim involves a vehicle:** a. Year, make and model \_\_\_\_\_

b. License Plate Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

c. At time of accident, were you (check all that apply): Owner \_\_\_\_ Driver \_\_\_\_ Passenger \_\_\_\_ N/A \_\_\_\_

d. Name and address of owner if different from claimant: (1. Above) \_\_\_\_\_

e. Name & address of driver if different from claimant: (1. Above) \_\_\_\_\_

Phone number of Driver \_\_\_\_\_ Date of Birth of Driver \_\_\_\_\_

f. Names / addresses / phone #s of all occupants of vehicle at the time of the incident \_\_\_\_\_

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

**3. Insurance:** a. What company insures the damaged vehicle? \_\_\_\_\_

b. Policy Number \_\_\_\_\_ Claim Number: \_\_\_\_\_

c. Name and address of your insurance agent or adjuster \_\_\_\_\_

\_\_\_\_\_ Type of Coverage \_\_\_\_\_

**4. Occurrence or event from which the claim arises:**

a. Date of incident \_\_\_\_\_ b. Exact location \_\_\_\_\_

c. Were you injured? Yes \_\_\_\_ No \_\_\_\_ Was anyone else injured? Yes \_\_\_\_ No \_\_\_\_

(If there was no injury, please state "No Injuries") \_\_\_\_\_

d. Nature and extent of any injuries \_\_\_\_\_

\_\_\_\_\_

e. If you were injured, name / phone / address of your treating doctor \_\_\_\_\_

f. **\*We are required to report all claims for injuries to Medicare/Medicaid Services \***

If you were injured please provide the following: Social Security #: \_\_\_\_\_

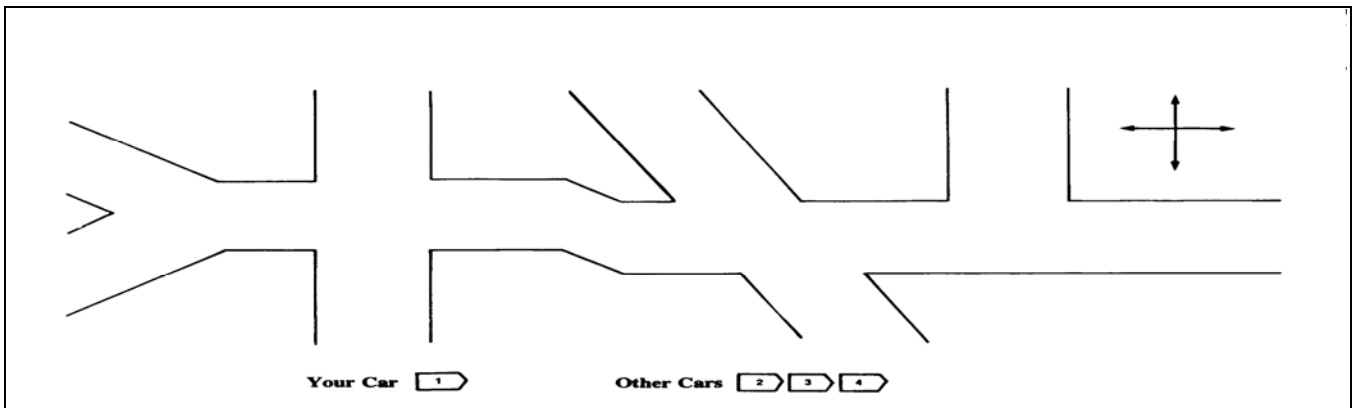
Medicare/Medicaid Beneficiary? Yes \_\_\_ No \_\_\_

g. Were you on the job at the time of the incident? Yes \_\_\_ No \_\_\_

If yes, what is the name / phone / address of your employer? \_\_\_\_\_

h. Name of City of Portland Driver \_\_\_\_\_ City vehicle license# \_\_\_\_\_

Names / Addresses / Phone Numbers of any witnesses to the incident: \_\_\_\_\_



5. **Description of Incident:** What happened? Give a full account, including the speed of each car and the direction each car was traveling. Please use the diagram above.

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

6. **Damages claimed:**

a. Amount claimed as of this date \_\_\_\_\_

b. Estimated amount of future costs \_\_\_\_\_

c. Total amount claimed \_\_\_\_\_

**WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085)**

I have carefully read the statements made in this claim, including any attached sheets, and they are true. I understand and acknowledge that all statements made in this claim are made to a public servant of the City of Portland, and that the statements are in connection with an application for a benefit from the City of Portland.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CLAIMANT'S SIGNATURE