

Mail completed form to:
Department of the Corporation Counsel
530 South King Street, Room 110
Honolulu, HI 96813

CLAIM FORM

FOR OFFICE USE ONLY

Claim No. _____

INSTRUCTIONS

- o This claim will not be processed unless filled in completely. **Please be as detailed and thorough as possible** - use additional paper for descriptions if necessary. Complete in ink.
- o Submit claim form with **any and all** supporting documentation.
 - Photos – area of occurrence, damages, injuries, etc.
 - Invoices – *Damages*: receipts or at least two estimates for repair; *Injuries*: medical reports and/ or bills
 - Copy of registration and insurance card (vehicle damage)
 - Police report number (if any)

Claims take approximately six (6) months to process.

CLAIMANT INFORMATION

Claimant Name: _____
Last *First* *M.I.*

Residence Address: _____
Street Address *Apartment/Unit #*

_____ *City* _____ *State* _____ *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email: _____

Occupation: _____

OCCURRENCE DESCRIPTION

Date of Occurrence: _____ Time of Occurrence: _____ Amount of Claim: _____

Location/ Address of Occurrence: _____

Description of Injury/ Damage: _____

How Injury/ Damage Occurred: _____

ADDITIONAL INFORMATION

Witness(s) to Accident/ Injury:

Name	Address	Phone No.
_____	_____	_____
_____	_____	_____

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) Section 111, requires the reporting of the following information.

Are you a Medicare beneficiary, or entitled to Medicare benefits? YES NO

Are you currently receiving benefits? YES NO

If the answer to the above question is YES, the following information must be provided:

Social Security No.: _____ Date of Birth _____ MALE FEMALE

NOTICE:

Filing a false claim is a violation of Hawaii Revised Statutes §46-171, et seq., and could result in a civil penalty of not less than \$5,000 and not more than \$10,000, plus treble damages.

BY SIGNING THIS FORM, I HEREBY CERTIFY THAT THE INFORMATION AND CLAIM SUBMITTED ARE TRUE AND CORRECT

Dated: _____

SIGNATURE OF PERSON FILING CLAIM