FIL	Æ	NO.	

DEPARTMENT OF LAW

CLAIM FORM

Claim Type:	(A). Vehicle damage					
	(B). Property damage (not vehicle)					
	(C). Personal injury (2-page Medicare/Medicaid form must be submitted with your claim for					
	(D). Other ☐ Claims cannot be paid without supporting documentation					
GENERAL INFO	ORMATION (THIS SECTION MUST BE COMPLETED).					
Claimant Nar	ne:Date of Birth:					
Complete Ad	dress:					
Phone No(s):	: ()/c_()					
Last Four (4)	Social Security Nos: Email address:					
Incident date	:Incident location:					
Briefly explai	n what happened:					
Name/addres	ss/phone of any witnesses, if any:					
(A). ONLY FIL	LL OUT SECTION (A) IF YOU HAVE SUSTAINED VEHICLE DAMAGE.					
Was a police	report filed? yes no If yes, Incident Report Number:					
If no, please	state why not					
•						
Ambulance o	called?					
vvere you tar	ken to the hospital? ☐yes ☐no If yes, list the hospital/address/phone:					
\\\ Doo!	a consultado Chas Chas Ificas list destario namo /oddroso/phone:					
vvas a Docto	or consulted? yes no If yes, list doctor's name/address/phone:					
Do you have	medical insurance/Medicare/Medicaid? yes no If yes, list type and polic					
•	nust attach a completed copy of the 2-page Medicare/Medicaid form if					
•						
, ,						

S:General Instructions/CLAIMS/ClaimForm 9/21/20

FILE NO.					
Has the vehicle been registered with the Michigan Secretary of State? ☐yes ☐no. If yes, please attach proof of registration to this claim form.					
Do you have auto insurance?					
Did you file a claim with your insurance company for this event? ☐yes ☐no If yes, was your claim approved or denied?					
Are you the owner of the vehicle involved in the auto accident? yes no If no, list the vehicle owner's name/address/phone:					
Describe the injuries/damages sustained and amount of damages being claimed. Please attach 2 estimates. Claims cannot be paid without supporting documentation.					
(B). ONLY FILL OUT SECTION (B) IF YOU HAVE SUSTAINED PROPERTY DAMAGE (NOT VEHICLE). Are you the property owner? yes no If no, list the name/address/phone of the property owner:					
Are you a tenant leasing or renting the property? ☐yes ☐no					
Do you have homeowner's/renter's insurance? ☐yes ☐no If yes, list name and policy number:					
Did you file a claim with your insurance company for this event? ☐yes ☐no If yes, was your claim approved or denied?					
Describe the damages sustained <u>and</u> amount of damages being claimed (Note: prior to the item(s) being inspected by the City, please take pictures of <u>all</u> damaged items and only discard items that may cause a health risk). To support the damage claim amount, please attach invoices, estimates, and receipts. Claims cannot be paid without supporting documentation.					

hone:
ne:
ype and policy orm if
If yes, was
se attach rting

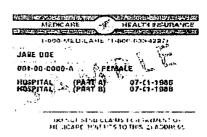
FILE NO	
Please describe the injuries/damages sustained <u>and</u> amount of damages being claimed. Please attach invoices, estimates, and receipts. Claims cannot be paid without supporting documentation.	
Please briefly list any other information not provided for in the above sections that you think will aid the City in processing your claim.	
I (CLAIMANT) DECLARE UNDER THE PENALTY OF PERJURY THAT THE FACTS STATED IN THAT THAT ARE TRUE TO THE BEST OF MY KNOWLEDGE. I FURTHER TO THE BEST OF MY KNOWLEDGE. I FURTHER TO THE BEST OF MY KNOWLEDGE.	
ACKNOWLEDGE THAT BY AFFIXING MY SIGNATURE TO THIS FORM THAT I HAVE NOT CAUSE A CLAIM TO BE FILED FOR ANY IMPROPER PURPOSE. Dated: Signature of Claimant	

RETURN FORM AND ATTACHMENTS TO: City of Dearborn, Department of Law 16901 Michigan Avenue, Suite 14, Dearborn, Michigan 48126-2729 (313) 943-2035 • FAX (313) 943-2469 The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

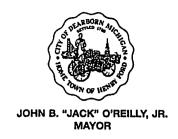


Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?							
f yes, please complete the following. If no, proceed to Se	ection II.						
ull Name: (Please print the name exactly as it appears	on your SSN or Medicare card if available.)						
Medicare Claim Number:	Date of Birth (Mo/Day/Year)	-					
Social Security Number: If Medicare Claim Number is Unavailable)	-	male	□Male				
section II understand that the information requested is to assist the cordinate benefits with Medicare and to meet its mandate							
Claimant Name (Please Print)	Claim Number						
Name of Person Completing This Form If Claimant is Unable (Please Print)							
ignature of Person Completing This Form	Date						

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III	
Claimant Name (Please Print)	Claim Number
Medicare beneficiary and I do not provide the re	ded the information requested. I understand that if I am a requested information, I may be violating obligations as a penefits to pay my claims correctly and promptly.
Reason(s) for Refusal to Provide Requested	l Information:
Signature of Person Completing This Form	
Signature of Ferson Completing This Form	vale



CITY OF DEARBORN

Home Town of Henry Ford

DEBRA A. WALLING, CORPORATION COUNSEL

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William H. Irving
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Jeremy D. Brown
Rebecca A. Schultz

MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW APPLICATION FOR BENEFITS

- 1. Claimant may have the right to personal protection insurance benefits, property insurance benefits, and/or residual liability benefits if in compliance with the regulations and restrictions contained in the Michigan No-Fault Insurance Law. Act 294, Public Act 1972, as amended.
- 2. The City of Dearborn will pay claims in a timely manner as prescribed by the Michigan No-Fault Insurance Law.
- 3. If there are any questions concerning the City of Dearborn's failure to fulfill its responsibilities under the Michigan No-Fault Insurance Law, please contact:

Department of Insurance and Financial Services PO Box 30220 Lansing, MI 48909-7720

(877) 999-6442