FILE 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 form)

(D). Other ☐

Claims cannot be paid without supporting documentation

GENERAL INFORMATION (THIS SECTION MUST BE COMPLETED).

Claimant Name: _____ Date of Birth: _____

Complete Address: _____

Phone No(s): (___) _____/c_(___) _____

Last Four (4) Social Security Nos: _____ Email address: _____

Incident date: _____ Incident location: _____

Briefly explain what happened: _____

_____

_____

_____

Name/address/phone of any witnesses, if any: _____

_____

(A). ONLY FILL 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 called? ☐ yes ☐ no

Were you taken to the hospital? ☐ yes ☐ no If yes, list the hospital/address/phone:

_____

Was a Doctor 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 policy (Note: you must attach a completed copy of the 2-page Medicare/Medicaid form if applicable).____

_____

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? ☐ yes ☐ no If yes, **please attach proof of insurance to this claim form.**

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 and amount of damages being claimed (Note: prior to the item(s) being inspected by the City, please take pictures of all 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.*** _____

_____

_____

FILE NO._____

_____

_____

***(C) ONLY** FILL OUT SECTION (C) IF YOU HAVE SUSTAINED PERSONAL INJURY.*

Was a police report filed? ☐ yes ☐ no If yes, Incident Report Number: _____

If no, please state why not _____

_____

Ambulance called? ☐ yes ☐ no

Were you taken to the hospital? ☐ yes ☐ no If yes, list the hospital/address/phone:

_____

Was a Doctor 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 policy (Note: you must attach a completed copy of the 2-page Medicare/Medicaid form if applicable).

_____

_____

Did you file a claim with your insurance company for this event? ☐ yes ☐ no If yes, was your claim approved or denied?

_____

_____

Describe the injuries sustained and amount of damages being claimed. **Please attach invoices, estimates, and receipts. *Claims cannot be paid without supporting documentation.***

_____

_____

_____

_____

***(D) ONLY** FILL OUT SECTION (D) IF NO OTHER SECTION IS APPLICABLE.*

Was a police report filed? ☐ yes ☐ no If yes, Incident Report Number: _____

If no, please state why not _____

_____

_____

FILE NO._____

Please describe the injuries/damages sustained and 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 THE ATTACHED DOCUMENT ARE TRUE TO THE BEST OF MY KNOWLEDGE. I FURTHER ACKNOWLEDGE THAT BY AFFIXING MY SIGNATURE TO THIS FORM THAT I HAVE NOT CAUSED A CLAIM TO BE FILED FOR ANY IMPROPER PURPOSE.

_____ Dated: _____

Signature of Claimant

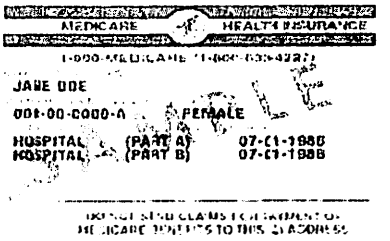
RETURN FORM AND ATTACHMENTS TO:
City of Dearborn, Department of Law
16901 Michigan Avenue, Suite 14, Dearborn, Michigan 48126-2729
(313) 943-2035 • FAX (313) 943-2469

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?	☐Yes	☐No
If yes, please complete the following. If no, proceed to Section II.		
Full 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)*	- - **Sex**	☐Female ☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature 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**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form	**Date**

Abdullah H. Hammoud
MAYOR

CITY OF DEARBORN
Home Town of Henry Ford

Jeremy J. Romer, CORPORATION COUNSEL

Deputy Corporation Counsel &
Chief Labor Negotiator
Jeremy J. Romer

Assistant Corporation Counsel
Bradley J. Mendelsohn
Ola F. Hammoud
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