CLAIM REPORT AND DEMAND

This claim must be filled out by the person making the claim against State and/or its employees. It is to be returned within 10 days to:

State of Minnesota
Risk Management
301 Centennial Bldg.
658 Cedar St.
St. Paul, MN 55155

1. CLAIMANT

Name of Claimant	Home Address
Date of Birth	City, State, Zip Code
Marital Status	Home Telephone
Name of Spouse	Business Address
Address of Spouse	Name of Employer
No. and Age of Dependents	City, State, Zip Code
Business Telephone	

2. ACCIDENT OR OCCURRENCE

Date	(a.m./p.m.) Time
Location	City, State
Weather Conditions	

Describe the accident or occurrence in detail: ______________________

Full names and addresses of all witnesses:

a. ______________________
b. ______________________
c. ______________________
d. ______________________
e. ______________________

Full name and address of each state agency and each state employee whom you claim caused your damages or injuries:

a. ______________________________
b. ______________________________
c. ______________________________

Full name and address of all other persons, companies, or governmental agencies whom you claim are responsible for your damages or injuries:

a. ______________________________
b. ______________________________
c. ______________________________

State the cause of the accident or occurrence:

____
____
____

3. DAMAGES OR INJURIES

Full name and address of injures person on whose behalf claim is here made (hereinafter "the injured"): ______________________________
____
____

(If a minor, include birthdate and parents' names)

Full name and address of other person(s) suffering injuries, if any:

a. ______________________________
b. ______________________________
c. ______________________________

Describe the injury, damages and losses incurred by the injured on whose behalf claim is made:

____
____
____
____

What was the injured doing at the time of the accident: ______________________________
____
____
____

If injury or damage was to property, state in detail the following:

a. What was damaged: ______________________________
____
____

b. Name of manufacturer: ______________________________
c. How old was is: ______________________________
d. What condition was it in at the time of the accident or occurrence: ______________________________
____

e. Any prior damage: If so, describe: ______________________________
____
____

f. Where purchased: ______________________________

g. If other than claimant, who owned it at the time of the accident: ______________

h. Any liens, mortgages, attachments, security interests or third party rights or claims outstanding on said property? If yes, state name and address:

i. Estimated cost of repair: ______________________________

j. Where is the damaged property now located: ______________________________

If injury or damages were to the person of the injured, state the following:

a. Where was the injured taken: ______________________________

b. Full name(s) and address of doctor first called or seen:

c. Full name(s) and address of any other doctor giving treatment or diagnosis:

d. Did injury arise out of or in the course of the injured's employment? __________

If so, describe: ______________________________

Any type of insurance coverage protecting claimant for the damages sustained? _________

If so, describe the kind of coverage and company: ______________________________

State the amount hereby claimed and demanded by you from the State: ______________

State the basis of the calculation of this amount: ______________________________

Have you made any other claims against the State and/or its employees? ______________

If so, state the date(s) and circumstances: ______________________________

I hereby certify that the foregoing statements and claim made by me are true. I am aware that if any statement made herein is to my knowledge false, in whole or in part, that I am subject to punishment provided by law.

Dated: ______________________________ ______________________________

Signature of Claimant