



NOTICE OF CLAIM

Please PRINT or TYPE info

Please be advised that an incomplete form will be returned, delaying processing.

Forward to:

Frank Leanza, Esq.
NJSEA
One DeKorte Park Plaza
P.O. Box 640
Lyndhurst, NJ 07071

This form should be submitted regardless of whether any other documentation has been furnished to the Authority. It is required that, pursuant to N.J.S.A. 59:8-6. the within form be completed in full detail. We are also requesting that you return a completed form to this office within 20 days.

1. Claimant:

Last Name First Middle Date of Birth Phone No.

Married Single Spouse's Name

Street /Mailing Address E-Mail

City State ZIP Social Security Number

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, complete question #2

Name Mailing Address

Relationship to Claimant City State ZIP

3. The occurrence of accident which gave rise to this claim occurred on:

a. Date / Time: b. City State

c. EXACT location of the occurrence (Stadium / Arena / Racetrack - seating section / parking lot #)

d. Describe in detail how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

e. State the name(s) of NJSEA employee(s) whom you claim were at fault, including any information that will assist in identifying and locating them.

f. State the negligence or wrongful acts of the NJSEA employee(s) which caused your damages.

g. State the name and address of all witnesses to the accident or occurrence.

h. State the name of all security personnel, police officers and/or police departments who investigated the accident and provide a copy of the incident or investigative report

4.a. *Claim for Damages (check appropriate space):*

Personal Injury Property Damage Other – Explain in detail.

b. *If you claim personal injury:*

(1) *Describe your injuries resulting from the accident or occurrence* _____

(2) *Do you claim permanent disability resulting from this injury:* Yes No

If yes, describe the injuries believed to be permanent.

(3) *Were you examined and/or treated by the Meadowlands Medical Department?*

Yes No.

(4) *For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic services, whether or not treatment is completed (“to be provided” is not an acceptable response) state (you may use a separate piece of paper if necessary):.*

Name of hospital, doctors or other facility	Address hospital, doctors or other facility	Dates of treatment or service	Amount of charges to date	Amount paid or payable by other sources, such as insurance

(5) Provide employment information whether or not any claim is being made for lost wages or lost time from work:

Name of Employer

Address of Employer

Your Occupation

Date you became employed

Rate of pay

Date of absence from work

Total lost wages to date

If still out, expected date of return

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income. If self-employed, a copy of your previous year's income tax records must be submitted.

(6) *Set forth any and all other losses or damages claimed by you.*

(7) *If you claim property damage:*

(a) *Describe the property damaged:*

(b) *The present location and time when the property may be inspected.* _____

(c) *Date property acquired:* _____

(d) *Cost of Property:* _____

(e) *Value of property at time of the accident:* _____

(f) *Description of damage:* _____

(g) Has the damage been repaired: _____ If so, by whom, when and costs of repairs.

(h) Attach an estimate of repair costs to this form. Two estimates required if damage exceeds \$750.

(i) Attach photographs of damaged property.

(j) Set forth in detail, the monetary loss claimed by you for property damage.

(k) Set forth in detail all other items of loss or damages claimed by you and the method by which you made calculation.

(l) The total amount of your claim: _____

8. a. Have you made a claim against anyone else for the losses or expenses claimed in this notice? _____ Yes _____ No

If yes, set forth the name and address of all persons and insurance companies against whom you have made such claims:

b. Have you applied for or do you receive, any benefits from any Municipal, State or Federal agency? _____ Yes _____ No

If so, state what agency: _____

9. Are any of the losses or expenses claimed herein covered by any policy of insurance? _____ For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

10. *Have you received or agreed to receive any money from anyone for the damages claimed therein?* _____

If so, set for the details of such agreement: _____

11. *The following items must be submitted with this notice (“to be provided” is not an acceptable response):*

- (1) Copies of itemized bills for each medical expense and other losses and expenses claimed.
- (2) Full copies of all appraisals and estimates of property damages claimed by you.
- (3) Copies of all written reports of all expert witnesses and treating physicians.
- (4) A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

12. *Prior claims.*

Have you ever made a claim before against the NJSEA or anyone else? _____ Yes _____ No
If so, list date of accident, location, parties involved, insurance carrier and claim number:

Have you made or presented any claim or request for remuneration, whether a lawsuit, workers compensation matter or insurance/liability claim?

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by the law.

Dated: _____

Claimant or person filing

TO WHOM IT MAY CONCERN:

I hereby authorize any and all doctors, hospitals, medical facilities and employers to release to NJSEA any and all records, reports, and other information concerning the treatment and/or employment of the claimant, herein named. This authorization shall remain in effect until my claim against NJSEA has been resolved.

The claimant will agree to execute and promptly return any required forms or authorizations needed by hospitals or providers to release information, including the full name and address of the provider being set forth in such an authorization by the claimant.

Dated: _____

X _____
(Signature)

Print your name

(This must be signed by claimant or the parent/guardian of claimant who is a minor or by legal representative)

Please Print Claimant's Name: _____

Date of Occurrence: _____



MEDICAL DEPARTMENT

One DeKorte Park Plaza
P.O. Box 640
Lyndhurst, NJ 07071
201-460-4111

Date: _____ Office use only: _____

Patient's Name: _____ DOB: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Incident: _____ ETR#: _____

Permission to Release Medical Records

I hereby give the NJSEA's medical records keeper permission to release my medical record(s) from (date): _____ and forwarding same to me and to forward same to NJSEA insurance company, if they request same.

Patient's or Guardian's Signature

After the medical record keeper at the NJSEA receives this signed permission form, your medical record will be forwarded to you.

Thank you,

Fran Guthrie, RN/s/
Medical Services Manager

A request for a medical report is not sufficient Notice of Claim against the New Jersey Sports and Exposition Authority. To make a claim, please contact the NJSEA legal department (201-842-5144).