

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**

_____	(a.m./p.m.) _____
Date	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