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**DAMAGE CLAIM FORM**

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**CLAIMANT INFORMATION**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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**OFFICIAL REPRESENTATIVE**

*(Person to whom all official notices and other correspondence should be sent, if other than Claimant above)*

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

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**INCIDENT DETAILS**

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ AM/PM

Location of Incident: \_\_\_\_\_

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**VEHICLES INVOLVED** *(if applicable)*

<b>Claimant Vehicle</b>	<b>Town Vehicle</b>
Year:	Year:
Make:	Make:
Model:	Model:
Plate:	Plate:
Mileage:	Department:

**BASIS OF CLAIM** – *State in detail the known facts and circumstances attending the incident identifying the persons and Town departments and property involved, and the cause thereof. Submit additional pages if necessary and attach photos if available. If a police report was completed, attach a copy.*

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**DESCRIPTION OF THE CLAIMANT’S DAMAGE, INJURY OR LOSS**

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**VALUE OF CLAIMANT’S LOSS OR INJURY** – *Enter the total amount that you are claiming as a result of the alleged damage or injury. Enter a breakdown of how the total amount that you are claiming was calculated. You may declare expenses incurred and/ or future anticipated expenses. If available, attach to the claim copies of all bills, payment receipts, and if an automobile accident, provide two repair estimates.*

**TOTAL DAMAGES CLAIMED:** \$ \_\_\_\_\_

**BREAKDOWN OF DAMAGES:**

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**WITNESS INFORMATION** *(if any)*

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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**YOUR INSURANCE INFORMATION**

Have you submitted a claim to any insurance company for damages arising from this incident?

Yes

No

If yes, please provide the following information:

Name of Insurer: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Email: \_\_\_\_\_

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I understand that if my claim is successful, any monies owed me may be offset by any monies I may owe the Town of West Springfield for such items as traffic tickets, unpaid bills, excise taxes, etc.

**I understand that submission of this does not constitute compliance with statutory notice provisions.**

***BY SIGNING MY NAME I AFFIRM, VERIFY, AND DECLARE, UNDER PENALTY OF PERJURY, THAT THE STATEMENTS MADE IN THIS FORM AND SUPPORTING MATERIALS ARE TRUE AND CORRECT.***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The claim must be signed by the claimant or by the official representative of the claimant under penalty of perjury. The Town will *Not Accept* the claim without an original signature. A photo-static copy or facsimile transmittal copy will not be accepted. Enter the date the claim is filed to assure compliance with time limitations.

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*CRIMINAL PENALTY FOR PRESENTING A FRAUDULENT CLAIM OR MAKING A FALSE STATEMENT CAN LEAD TO IMPRISONMENT OR FINE OR BOTH.*

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**PLEASE PRINT LEGIBLY OR TYPE ON THIS FORM.**

**Return completed and signed claim form to:**

Office of the Town Clerk  
Municipal Office Building  
26 Central Street, Suite 8  
West Springfield, MA 01089