# KENTUCKY CLAIMS COMMISSION 500 Mero Street, 2SC1, Frankfort, Kentucky 40601, 502-782-8255

# **CLAIM FORM GENERAL INSTRUCTIONS**

You must use ink or type the information. Although no filing fee is charged, the signed claim form with all evidence attached <u>is required</u>. If an attorney is involved, the claimant and the attorney must sign the claim form. KRS 49.180 states no claim shall be brought before the commission unless the total amount of damages claimed is \$250 or greater. The maximum award shall not exceed a single individual award of \$250,000 and multiple claims shall not exceed a total award of \$400,000 for a single act of negligence.

- Section I. Information about the <u>claimant only</u>.
- Section II Name the State agency involved.
- Section III. The name of the person that referred you to the KY Claims Commission.
- Section IV. Date and time of the incident. Must generally be filed within one year.
- Section V. Provide incident information. **Be specific**.
- Section VI. Give a complete incident description
- Section VII Describe completely how the state agency or employee was at fault.

Section VIII. State the exact dollar amount of your claim and include itemized receipt(s), OR at least two repair estimates for damages

Section IX. Complete this section if a motor vehicle was involved, with a copy of the police report, if any. You must submit verification of the amount of your deductibles on your car insurance policy, i.e., either insurance declaration page or insurance card if the deductibles are listed on it.

Personal Injuries must be supported with proper documentation, insurance policy numbers, effective dates etc. Other damage must be supported with proper insurance information, policy number, effective dates and deductible.

The KY Claims Commission accepts claim forms by mail, fax, or email.

No claims can be granted for the following:

- Claims under \$250.
- Claims for pain and suffering.
- Collateral, dependent or subrogation claims.
- Claims where a state agency has no jurisdiction (i.e., areas or events where legal responsibility lies with contracted entities or non-state agencies).

# YOU MUST SIGN as the claimant and you MUST provide your Social Security or Federal ID before your claim can be investigated or submitted for a hearing.

Commonwealth of Kentucky Public Protection Cabinet Kentucky Claims Commission 500 Mero Street 2SC1 Frankfort, KY 40601 Telephone: (502) 782-8255 Fax: (502) 573-4817 Email: negligenceclaims@ky.gov

### **CLAIM FORM**

#### COMPLETE ALL SECTIONS THAT APPLY TO YOUR SPECIFIC CLAIM

Through KRS 49.020, the Kentucky Claims Commission is vested with authority to compensate persons for damages sustained to person or property as a result of **negligence** on the part of the Commonwealth. The burden of proof that the Commonwealth was negligent rests with you. **The Kentucky Claims Commission will not find the Commonwealth negligent simply because an incident occurred on state property; fault must be found.** Negligence must be proven before an award can be made. Please provide all facts, statements by witnesses (in writing), or any other proof you have that you believe would be helpful in the determination of your claim.

Claims for damages must be at least two hundred fifty dollars (\$250.00). An original or a copy of the form may be delivered for filing by mail, fax, or email.

I.

Claimant's Name

Address

City, State and Zip Code

(\_\_\_\_)\_\_\_\_\_ Daytime telephone number (\_\_\_\_)\_\_\_\_ Mobile telephone number

Email address

II.

Name of State Agency involved with the incident (employee's name, if known)

III. Who referred you to the KY Claims Commission?\_\_\_\_\_

IV.\_\_\_\_

Date and time of the incident (all claims generally shall be filed within one year of incident)

V.\_\_\_\_\_

\_\*\* County\_\_\_

Location where the incident occurred. Please provide **exact** location including **direction** (North, South, East or West), mile marker, name or number of road, intersection, etc. PLEASE BE SPECIFIC so that your claim may be thoroughly investigated.

VI. Describe the incident and the damage done to you or your property.

VII. In what way do you believe the state agency or employee was at fault? What more could the state have done?

VIII. State the specific dollar amount of your claim. \$\_\_\_\_\_

Submit bills, receipts and/or **TWO** repair estimates as proof of the cost of damages sustained. **This amount will be amended according to the amount you have a right to receive from your insurance regardless whether you file a claim with your insurance company**.

IX. If motor vehicles were involved, please complete the following:

#### STATE VEHICLE:

Tag number, if known\_\_\_\_\_

Driver, if known

#### CLAIMANT'S VEHICLE: (This claim must be filed and signed by the registered owner.)

In whose name is the vehicle registered?

Vehicle year, make and model: \_\_\_\_\_

Name and address of driver and passengers:

Name of law enforcement authority or officer who investigated the incident:

Please submit a copy of police report, incident report, or Uniform Traffic Report if possible.

Pursuant to KRS 49.020(1), the Commission can only award what you cannot recover through insurance or any other source. The Commission <u>must reduce</u> any award by the amount you have a right to receive from any insurance coverage, even if no claim was filed with your insurance company. In order to review your claim as submitted, provide all information below that relates to the damages you incurred.

# VEHICLE INSURANCE <u>You must submit your insurance declaration page</u> <u>OR insurance card if the deductibles are listed on the card</u>

1) Insurance Agent and Address:			
2) Insurance Company:			
Policy Number:			
Effective Dates:			
3) Collision Coverage in Effect: ()Yes ()No		Amount of Deductible \$	
4) Comprehensive Coverage in Effect: ()Yes ()No		Amount of Deductible \$	
5) Liability Coverage only: ()Yes ()No	)		
	only if you are m	Y INSURANCE aking a claim for personal injury) Dental Insurance in Effect: ( ) Yes (	( ) No
Name of Insurance Company:			
Policy Number:	Number: Effective Dates:		
mount of Deductible: Has this deductible been met for the year?()Yes ()No			
7) Compensation Insurance Coverage ir	n Effect: ( )Yes (	)No	
Name of Company:			
Policy Number:	Effec	tive Dates:	
Deductible:	Has this deductible been met yet for this year? ()Yes ()No		'es ( )No
8) If you have <i>any other insurance cov</i> subject of your claim, please list what ty	•		which are th

# OTHER INSURANCE

9) Homeowner	Dwelling or Mobile Home Coverage		
Name of Company:			
Policy Number:	Effective Dates:		
Deductible:	Has this deductible been met yet this year? ( )Yes ( )No		
	her insurance coverage that would entitle you to recover the damages, which are the blease list what type and the amount of the deductible if any.		
<u> </u>			
YOU MUST SIGN :	Claimant's Signature:		
	Address:		
	Daytime Telephone:(work)Telephone:		
	Mobile Telephone:		
	Date:		
WE MUST HAVE:	Social Security Number or Federal ID Number:		
	Attorney's Name:		
	Attorney's Signature:		
	(if represented by Counsel)		
	Address:		
	Telephone:Date:		
	Federal ID Number:		

Claims generally must be presented to the Kentucky Claims Commission within one year from the date of the incident. There are exceptions for personal injury and for medical malpractice claims.