



# Claim against the City of San Mateo

Pursuant to Government Code 910, subject to certain limited exceptions, a claim must be filed with the City of San Mateo within six (6) months of the incident. Completed forms must be mailed or hand-delivered or emailed to:

City Clerk, City of San Mateo, 330 West 20<sup>th</sup> Avenue, San Mateo, CA 94403

E-mail: [claims@cityofsanmateo.org](mailto:claims@cityofsanmateo.org)

Please complete each section and print clearly. Attach any invoices, receipts, estimates, photos, or other documentation that support the claim for damages.

Claimant's Full Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's License: State: \_\_\_\_\_ No.: \_\_\_\_\_

Gender: (circle) Male or Female Home phone.: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

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

Claimant's Address: \_\_\_\_\_  
Street Apt. No.

City State Zip

Address where notices should be sent if different from claimant's address:

Name Business/Company

Telephone Email Address

Street Apt. No.

City State Zip

Date of Incident: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Time of Incident: \_\_\_\_\_ (circle) AM or PM

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

**CAUSE OF LOSS:** Detailed description of the event, act, or omission which you allege caused the injury or damage for which you are submitting this claim.

Name(s) of Public Employee(s) causing injury, damage, or loss: \_\_\_\_\_

Name and telephone number of any known witnesses: \_\_\_\_\_

**DESCRIPTION OF LOSS** (Describe injury, property damage, or loss. If there were no injuries, state "No Injuries."): Please use second page if necessary.

**AMOUNT CLAIMED:** \$ \_\_\_\_\_

And the Basis for this total:

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The Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report SSNs in order for Medicare to coordinate payments with other insurance benefits. Individuals who receive ongoing reimbursement for medical care through no-fault insurance, Workers' Compensation, or who receive a settlement, judgment, or award from liability insurance/self-insurance or Workers' Compensation, will be asked to furnish information concerning their SSN. In order for the City to comply with the mandatory reporting requirements of the Medicare, Medicaid and S-chip Extension Act of 2007, the following information is required:

Are you presently or have you ever been enrolled in Medicare Part A or B? (circle) YES or NO

IF YES, PROVIDE MEDICARE NUMBER : \_\_\_\_\_  
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I certify that the forgoing is true and correct. Submitted by:

Claimant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Attorney or Representative Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**WARNING:** It is a criminal offense to intentionally file a false or fraudulent claim and is punishable by imprisonment for up to one (1) year or a fine of up to \$10,000, or both (Penal Code Section 72).