STANDARD CLAIM FORM
PLEASE TYPE OR PRINT IN INK

PERSONAL INFORMATION

1. CLAIMANT'S NAME:

Last Name             First              Middle                 Date of Birth (mm/dd/yyyy)
________________________________________________________________

2. RESIDENCE ADDRESS (at time of incident):

________________________________________________________________

3. MAILING ADDRESS (IF DIFFERENT):
   __________________________________________________________________

4. DAYTIME TELEPHONE: (          ) ________________ (          ) _______________
   Home    Business

5. E-mail____________________________________________________________

INCIDENT INFORMATION

6. DATE OF INCIDENT:  ________/________/________
   month         day           year

7. TIME:  _______  A.M. / P.M. (CIRCLE ONE)

8. LOCATION OF INCIDENT:
   __________________________________________________________________
   Address                          City                          County

9. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL PERSONS INVOLVED, OR
   WITNESS, TO THIS INCIDENT: (Attach additional sheets if necessary)
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________
10. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF ALL COMMUNITY TRANSIT EMPLOYEES HAVING KNOWLEDGE ABOUT THIS INCIDENT: (Attach additional sheets if necessary)

________________________________________________________________________

________________________________________________________________________

11. DESCRIBE CONDUCT AND CIRCUMSTANCES CAUSING INJURY OR DAMAGES, EXPLAINING EXTENT OF MEDICAL, PHYSICAL, OR MENTAL INJURIES (ATTACH ADDITIONAL SHEETS, IF NECESSARY):

________________________________________________________________________

________________________________________________________________________

12. NAME, ADDRESS, AND TELEPHONE NUMBER OF TREATING PHYSICIAN(S) AND ATTACH COPIES OF MEDICAL REPORTS AND BILLINGS:

________________________________________________________________________

________________________________________________________________________

13. I / WE DO HEREBY CLAIM DAMAGES FROM ___________________ IN THE SUM OF $____________.

(To Be Determined (TBD) is appropriate if you do not have a Damage Estimate or have not completed medical treatment.)

CLAIMANT OR LEGAL GUARDIAN MUST SIGN THIS CLAIM FORM

I certify or declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant __________________________________________ Date and Place (address, city and county)

If the claimant is incapacitated from verifying, presenting, and filing the claim of if the claimant is a minor, or is a nonresident of this state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant. All claims for the damages against Washington State Transit Insurance Pool Members arising out of tortuous conduct shall be presented to and filed with the appropriate transit property.