



# Clallam County Fire District 3

Motto: *Serve, Respect,  
Prevent and Protect*

323 N Fifth Ave  
Sequim, WA 98382  
[ccfd3.org](http://ccfd3.org)

## Standard Tort Claim Form Packet

**NOTE:** All documents received by Clallam County Fire District 3, herein referred to as CCFD3, become the property of CCFD3 and **will not be returned**. Please keep a copy for your records and do not send original attachments if you may want them returned.

Please *carefully read all of the information in this packet* before completing and presenting your Standard Tort Claim. Tort claims are subject to public disclosure pursuant to RCW 42.56.

**Presenting a Standard Tort Claim Form** – RCW 4.92.100 requires citizens to present the Standard Tort Claim form with the government agency named in their claim. The law also requires State and local government agencies to post on its website the Standard Tort Claim form with instructions. In compliance with these requirements and for the convenience of citizens, the State Office of Financial Management (OFM) developed a Standard Tort Claim Form Packet.

### Documents Contained in the Standard Tort Claim Form Packet

1. Instructions for completing the Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization (only for tort claims involving bodily injury)
4. Vehicle Collision Form (only for tort claims involving vehicle accidents/collisions)
5. Mandatory Medicare Beneficiary Reporting Form

**Legal Requirements for Presenting Standard Tort Claim Forms** – In order to verify the claim and additional supporting information, the law requires that the Standard Tort Claim form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney in fact for the Claimant; or
- Attorney admitted to practice in Washington state on the Claimant's behalf; or
- A court-approved guardian or guardian ad litem on behalf of the Claimant

### Mail the Standard Tort Claim Form & Supporting Documents to:

Clallam County Fire District 3  
ATTN: Finance Manager  
323 N Fifth Ave.  
Sequim, WA 98382

### Or present in person, during business hours, the Standard Tort Claim Form & Supporting Documents to:

Clallam County Fire District 3  
ATTN: Finance Manager  
863 Carlsborg Road, Unit C  
Carlsborg, WA 98324

## Instructions for Completing A Standard Tort Claim Form

**Instructions:** Before filing a claim, please read these instructions, the Tort Claim form and other appropriate forms in their entirety. Type or print clearly in ink and sign the Standard Tort Claim form.

Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

The following are *examples* provided to illustrate how to complete the Tort Claim Form

1. Doe, John Conner, 12/01/1910
2. 222 One Way Street, Apt. Z, Seattle, Washington 98178
3. Post Office Box 111, Seattle, Washington 98178
4. Same
5. (206) 555-5555
6. January 1, 2009, 8:00 a.m.
7. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item (7).
8. Washington, Thurston, Tumwater, parking lot of XYZ Cleaners.
9. I-5, southbound, Milepost, near XYZ Exit.
10. XYZ Barone Sanitation
11. Fitzgerald III, Mortimer, 3287 Wonderful Lane, Seattle, Washington 98187, (360)111-1111; tow truck driver, XYZ Towing.
12. Unknown
13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items (11) and (12). Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
14. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
15. If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
16. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include medical records and bills.
17. Attach documents which support the claim's allegations.
18. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss etc. This amount should represent your opinion of total compensation.
19. If you were injured, please complete the Medicare Verification form (attached).

**Note:** If you are filing a personal injury claim, please sign and attach the Medical Release. If your claim involves a motor vehicle accident, please complete, sign, and attach the vehicle accident form.

STANDARD TORT CLAIM FORM
General Liability Claim Form

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim against Central Pierce Fire & Rescue. Some of the information requested on this form is required by RCW 4.92.100 and is subject to public disclosure.

Instructions: Please type or print clearly in ink. Mail or present in person, during business hours, the Standard Tort Claim Form & Supporting Documents to: Clallam County Fire District 3, ATTN: Finance Manager, 323 N Fifth Ave., Sequim, WA 98382. Business Hours: Mon -Fri 8:00 a.m. to 5:00 p.m. Closed on weekends and official state holidays

CLAIMANT INFORMATION

- 1. Claimant's name: (Last name) (First) (Middle) (Date of birth: mm/dd/yyyy)
2. Current residential address:
3. Mailing address (if different):
4. Residential address for six months prior to the incident date (if different from current address):
5. Claimant's daytime telephone numbers: Home phone: Business or Cell: E-mail address:

INCIDENT INFORMATION

- 6. Date of the incident: (mm/dd/yyyy) Time: a.m. p.m. (check one)
7. If the incident occurred over a period of time, date of first and last occurrences: From: (mm/dd/yyyy) Time: a.m. p.m. To: (mm/dd/yyyy) Time: a.m. p.m.
8. Location of incident: (State and county) (City, if applicable) (Place where occurred)
9. If the incident occurred on a street or highway: Name of street or highway Address/Milepost # Place where the incident occurred:
10. District or agency alleged responsible for damage/injury:
11. Names, address, and telephone numbers of all persons involved in or witness to this incident:

12. Names, addresses, and telephone numbers of all persons involved in or witness to this incident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Names, addresses, and telephone numbers of all individuals not already identified in (11) and (12) above that have knowledge regarding the liability issues involved in this incident, or knowledge of the claimant’s resulting damages. Please include a brief description as to the nature and extent of each person’s knowledge. Attach additional sheets if necessary. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

15. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom? \_\_\_\_\_

\_\_\_\_\_

16. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

\_\_\_\_\_  
\_\_\_\_\_

17. Please attach documents which support the claim’s allegations.

18. I claim damages in the amount of \$ \_\_\_\_\_

19. If you are injured, are you a Medicare beneficiary?  Yes  No (check one) If Yes, please complete the Medicare Verification form.

Additional Information Required for Automobile Claims Only

License Plate #: \_\_\_\_\_ Driver License # \_\_\_\_\_

Type Auto: \_\_\_\_\_  
(year) (make) (model)

Driver: \_\_\_\_\_ Owner: \_\_\_\_\_

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

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Passengers:

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

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

\_\_\_\_\_  
\_\_\_\_\_

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

This Claim form must be signed by one of the following (check appropriate box).

- Claimant
- Person holding a written power of attorney from the Claimant
- Attorney in fact for the Claimant
- Attorney admitted to practice in Washington State on the Claimant's behalf
- Court-approved guardian or guardian ad litem on behalf of the Claimant

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

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X \_\_\_\_\_

X \_\_\_\_\_

Signature of Claimant(s)

Subscribed and sworn to before me this day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC in and for the State of Washington

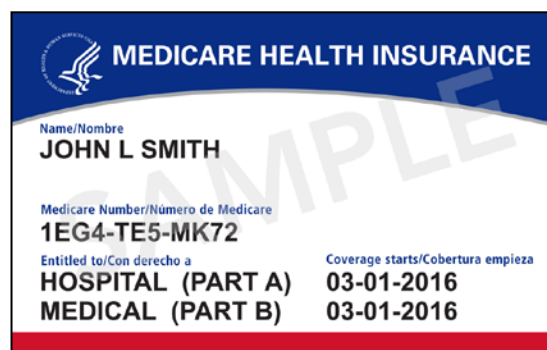
## MMSEA REPORTING COMPLIANCE DECLARATION

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance, However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays,

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans s-o that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



### Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please complete the following. If no, proceed to Section II.			
<b>Full Name:</b> (Please print the name exactly as it appears on your SSN or Medicare card if available)			
<input type="text"/>			
Medicare Number:		Date of Birth	
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>	
<b>**Social Security Number:</b> (If Medicare number is unavailable)		<input type="checkbox"/> Female <input type="checkbox"/> Male	

\*\* Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

**Section II**

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

\_\_\_\_\_  
Claimant Name (Please Print)

\_\_\_\_\_  
Medicare Number

\_\_\_\_\_  
Name of person completing this form if claimant is unable (Please Print)

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date

*If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.*

**Section III**

\_\_\_\_\_  
Claimant Name (Please Print)

\_\_\_\_\_  
Medicare Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date