

Notice of Claim Instructions

If you wish to make a claim against the State of New Jersey, please read the following information:

The State of New Jersey is protected from Tort actions by State Statute Title 59, and more specifically, Chapter 9, Paragraph 2e. Simply stated, Title 59: 9-2e means that, if you have insurance to cover "physical damage" to your property, the money you are entitled to receive under such policy of insurance shall be deducted from your claim against the State.

To expedite settlement of your claim, we ask that you settle your physical damage with your physical damage insurance carrier.

You may submit a claim for your deductible by forwarding a copy of your estimate and a copy of the declaration sheet showing the amount of your physical damage deductible to the address listed below.

If you do not have "physical damage" coverage and wish to submit a claim, please forward an estimate for the damage, a copy of the declaration sheet on your insurance policy, and complete the enclosed Tort claim form.

Since all claims which are filed against the State of New Jersey must be filed within 90 days of their occurrence, we suggest that your documentation be sent via certified mail. Although this is not required, it will insure that you have proof of receipt by this office.

Should our investigation reveal that the State is liable for your damage, you will be compensated.

Please allow a minimum of 90 days for a reply to your claim submittals.

Mail your response to:

Dept. of Treasury
Bureau of Risk Management
P.O. Box 620
Trenton, NJ 08625
Attn.: Tort Claims Unit

INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST THE STATE OF NEW JERSEY

FORWARD TO: TORT AND CONTRACT UNIT, CLAIMS SERVICE SECTION
DEPARTMENT OF THE TREASURY, BUREAU OF RISK MGT.
CN 620
TRENTON, NEW JERSEY 08625
PHONE: (609) 292-4347

☆FORM MUST BE FILED WITHIN 90 DAYS OF THE ACCIDENT OR YOU MAY FORFEIT YOUR RIGHT☆

1. NAME OF CLAIMANT STREET ADDRESS
DATE OF BIRTH CITY STATE ZIP CODE
DAYTIME PHONE #/CONTACT SOCIAL SECURITY NUMBER

2. **IF IT IS REQUESTED THAT NOTICES BE SENT TO A PERSON OTHER THAN THE CLAIMANT, SUCH AS YOUR ATTORNEY, PLEASE SEND NOTICES TO:**

NAME OF PERSON STREET ADDRESS
TELEPHONE NUMBER CITY STATE ZIP CODE
RELATIONSHIP TO CLAIMANT: ☐ ATTORNEY ☐ OTHER (SPECIFY)

3. **CIRCUMSTANCES REGARDING THE OCCURRENCE OR ACCIDENT:**

DATE AND TIME LOCATION
CITY STATE

4. **DESCRIBE THE ACCIDENT OR OCCURRENCE:**

_____.

5. STATE THE NAME AND ADDRESS OF ALL WITNESSES TO ABOVE OCCURRENCE:

6. STATE THE NAMES AND ADDRESSES OF EACH STATE AGENCY AND EACH STATE EMPLOYEE WHOM YOU CLAIM CAUSED YOUR DAMAGES OR INJURIES.

7. STATE THE NAME AND ADDRESS OF ALL OTHER PERSONS, COMPANIES, OR GOVERNMENTAL AGENCIES WHICH YOU CLAIM ARE RESPONSIBLE FOR YOUR INJURIES OR DAMAGES.

8. BRIEFLY DESCRIBE THE INJURY, DAMAGES AND LOSSES INCURRED BY YOU.

9. GIVE THE AMOUNT THAT YOU CLAIM IN DAMAGES: \$_____

GIVE THE BASIS FOR CALCULATION OF THE ABOVE DAMAGES:

I certify that the foregoing statements made by me are true. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

DATE: _____

CLAIMANT OR PERSON FILING ON BEHALF OF CLAIMANT