



## **CLAIM FOR DAMAGES INFORMATION**

The Claim For Damages form should be filled out by the claimant, notarized and returned to the City Clerk with any substantiating documents you wish to present with your claim. The staff at City Hall can notarize the form for you at no cost. You may return the completed form to City Hall or mail it to:

City Clerk  
City of Enumclaw  
1339 Griffin Ave  
Enumclaw, WA 98022

Upon receipt of the completed Claim For Damages form, the appropriate City departments will review and document the claim and forward it to our insurance company, Washington Cities Insurance Authority (WCIA). The insurance company will subsequently contact you. After the claim has been sent to WCIA, all inquiries regarding the status of the claim must be directed to them at 206-575-6046.

If you have any questions, please call me at 360- 615-5627.

Sincerely,

Katy McKee  
Deputy City Clerk

# CLAIM FOR DAMAGES FORM

Date Claim Form  
Received by Member

MEMBER CITY/ORGANIZATION: CITY OF ENUMCLAW

Please take note that \_\_\_\_\_, who currently resides at \_\_\_\_\_, mailing address \_\_\_\_\_, home phone # \_\_\_\_\_, work phone # \_\_\_\_\_, and who resided at \_\_\_\_\_ at the time of the occurrence is claiming damages against \_\_\_\_\_ in the sum of \$ \_\_\_\_\_ arising out of the following circumstances listed below.

DATE OF OCCURRENCE: \_\_\_\_\_ TIME: \_\_\_\_\_

LOCATION OF OCCURRENCE: \_\_\_\_\_

**DESCRIPTION:**

1. Describe the conduct and circumstance that brought about the injury or damage. Also describe the injury or damage  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (attach an extra sheet for additional information, if needed)

2. Provide a list of witnesses, if applicable, to the occurrence including names, addresses, and phone numbers.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Attach copies of all documentation relating to expenses, injuries, losses, and/or estimates for repair.

4. Have you submitted a claim for damages to your insurance company? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please provide the name of the insurance company: \_\_\_\_\_ and the policy #: \_\_\_\_\_

** ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY **			
License Plate # _____	Driver License # _____		
Type Auto: _____	_____		
(year)	(make)	(model)	
<b>DRIVER:</b> _____	<b>OWNER:</b> _____		
Address: _____	Address: _____		
Phone#: _____	Phone#: _____		
<b>Passengers:</b>			
Name: _____	Name: _____		
Address: _____	Address: _____		

\* \* NOTE: THIS FORM MUST BE SIGNED AND NOTARIZED \* \*

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)

State of Washington  
County of \_\_\_\_\_

I certify that I know or have satisfactory evidence that \_\_\_\_\_ is the person who appeared before me, and said person acknowledged that (he/she) signed this instrument and acknowledged it to be (his/her) free and voluntary act for the uses and purposes mentioned in the instrument.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title  
My appointment expires \_\_\_\_\_