DEPARTMENT OF ADMINISTRATION
CLAIMS BOARD

CLAIM FOR DAMAGES AGAINST THE STATE

Submit one notarized copy of this form to the Claims Board, P.O. Box 7864, Madison, Wisconsin 53707-7864. Attach proof of loss; copies of all bills, receipts and insurance proceeds; and copies of medical and/or police reports, if applicable. If you have insurance coverage, complete the insurance portion of this form, regardless of whether or not you have submitted claim to your insurance company. Do not request reimbursement for damages paid by your insurance company on this form. If your insurance company wishes to file a claim for reimbursement, they must file on a separate form. If more space is needed for comments, continue on another page and attach. This information will be sent to the appropriate department or agency.

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

|  |  |
| --- | --- |
| Claimant's Name, Address and Phone                                   | Date of Occurrence                  |
|    | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|    | State Agency Claim is Against  |
|    |     |

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

Statement of Circumstances - Explain how claim arose.

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

Dollar Amount of Claim. Itemize all losses incurred. Atach copies of all bills and/or receipts.

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

Insurance Coverage on above losses: \_\_\_\_yes \_\_\_\_no.
If yes, state amount: $\_\_\_\_\_\_\_\_ Amount of Deductible: $\_\_\_\_\_\_\_\_
Vehicle Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Homeowner Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Medical Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I hereby certify that all statements contained herein and on any attachments hereto are true and that the losses claimed were actually incurred.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Signature of Claimant | Date |

The above-named claimant personally came before me this day and is known to me to be the person who executed the foregoing instrument and acknowledged the same.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Notary Public | Date |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County, Wisconsin                My Commission Expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_