Solid Waste Authority of Central Ohio

Claimant Statement Form

NAME	BIRTH DATE	HOME PHONE	CELL PHONE
STREET ADDRESS	CITY	STATE	ZIP
EMAIL ADDRESS	EMPLOYER NAME		

<table>
<tr><td colspan="2">NAME OF SWACO EMPLOYEE INVOLVED IN INCIDENT:</td><td>POLICE REPORT MADE?
YES
NO</td></tr>
<tr><td colspan="3">TYPE OF DAMAGE: VEHICLE INJURY OTHER PROPERTY</td></tr>
<tr><td colspan="2">POLICE REPORT NO.:</td><td>IF NO REPORT, WHY?</td></tr>
<tr><td>INCIDENT DATE:</td><td>INCIDENT TIME:</td><td>ADDRESS OF INCIDENT:</td></tr>
</table>

DETAILED DESCRIPTION OF INCIDENT

WITNESS NAME	PHONE	ADDRESS
WITNESS NAME	PHONE	ADDRESS

FOR VEHICLE DAMAGE CLAIMS OR AUTOMOBILE ACCIDENTS

VEHICLE MAKE/MODEL:	YEAR:	LICENSE PLATE #:	MILEAGE:

OWNER'S NAME:	OWNER'S ADDRESS & PHONE:	
DRIVER'S NAME:	DRIVER'S ADDRESS & PHONE:	
TWO REPAIR ESTIMATES (ATTACH ESTIMATE DOCUMENTS)	(1) $	(2) $
# OF PEOPLE IN YOUR VEHICLE:	PASSENGERS:	

FOR DAMAGE CLAIMS OTHER THAN VEHICLE DAMAGE

WHAT PROPERTY WAS DAMAGED:
CAUSE OF DAMAGE:
AGE OF DAMAGED PROPERTY:
REPLACEMENT, RESORTATION, OR REPAIR COST (IF MORE THAN ONE ITEM, FILL OUT THE ITEMIZED PROPERTY CLAIM PAGE):

FOR PERSONAL INJURY CLAIMS

NATURE & EXTENT OF YOUR INJURY
HOSPITAL TRANSPORTED TO:

AFFIDAVIT OF INSURANCE

A copy of your auto or home owners' insurance declaration page must accompany this claim packet.

HEALTH INSURANCE COMPANY:
AUTO INSURANCE COMPANY:
AUTO INSURANCE POLICY NUMBER:
HOME OWNERS INSURANCE COMPANY:
HOME OWNERS INSURANCE POLICY NUMBER:

If uninsured, please complete the following:

I _________________, swear and affirm that I do not have the following type(s) of insurance:

Auto Medical Home Owners Renters (Check all that apply)

Alternately, I _________________, swear or affirm that I/my company is self-insured.

I further state that I am not entitled to receive additional reimbursement for these injuries and/or damages from any other source other than the Solid Waste Authority of Central Ohio and that the claim(s) arising from these injuries and/or damages are a direct result of this incident.

The Ohio Revised Code, Section 2744.05 outlines limitations of damages awarded for claims against political subdivisions. If a claimant receives or is entitled to receive benefits from insurance policy or policies, that amount will be deducted from any award the political subdivision may consider paying. This includes Medicaid, Medicare, and auto policies. You <u>must</u> file a claim with your insurance company prior to filing a claim with the Solid Waste Authority of Central Ohio.

CLAIMANT'S SIGNATURE ________________________________ DATE ______________________

Sworn (or affirmed) and subscribed before me this _____ day of _______________, 20_____.

____
NOTARY PUBLIC

SOLID WASTE AUTHORITY OF CENTRAL OHIO

Claimant Statement Form

Itemized Property Claim Form

Property Description (including brand name & serial #)	Quantity	Date Purchased or Age	Purchase Price	Replacement, Restoration, or Repair Cost