TRIMET CLAIM REPORT

(For damages to persons or personal property)

For office use only: File: Date:

A claim must be filed with the Claims department of TriMet within 180 days of the incident. Be sure your claim is with TriMet, not another public entity. Where space is insufficient, please use additional paper and identify information by paragraph number. Completed forms may be mailed, emailed, or faxed to: TriMet, Dept. RM, 4012 SE 17th Avenue, Portland, OR 97202, Fax 503-962-7555, email: liabilityclaims@trimet.org

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1. YOUR FULL NAME: ________________________. **Birth Date:** ____________
Mailing Address: ____
City: __________________________ State: __ Zip Code: ____________
Telephone # (home): ______________________ (cell): _______________________
Email: ____
Social Security #: ____________ Occupation: ______________________________
Marital Status: Single Married Divorced Widowed
If married, name of spouse: ____

2. DO YOU OWN A VEHICLE ? Yes: No:
At the time of accident, were you: Owner Driver Passenger N/A
Name and address of owner if different from driver: ___________________________________
____
License plate #: ________ Driver's license #: ____________ State: _____
Make, model, year and color of the vehicle: ____
Company that insures the vehicle: ____
Insurance company phone #: ____________ Policy/claim #: _____________________
Have you reported this to your Insurance company ? Yes NO

3. OCCURRENCE OR EVENT FROM WHICH THE CLAIM ARISES:
Date: _________ Time: ________ Check one: AM PM

Place of accident (specific bus/rail stop, street name): ________________________________
Bus/train#: ____
Route#: _____ Direction of travel: ______ TriMet Incident # (if known): ______
What time did you board? AM PM Boarding stop location: _____________
Where were you going? ____
Where were you seated on the bus or train? ____
Description of yourself and what you were wearing (to locate on cameras):
____
Description of operator (i.e., male/female, badge #, etc.):
____

Specify the particular event/occurrence, act or omission that you believe caused the injury or damage (use additional paper if necessary):

____
____
____
____

TRIMET

____
____

Name and address of your employer:
____

Were you on the job at the time of the incident? Check one: Yes No

4. Give a description of the injury, property damage or loss. If there were no injuries, state "no injuries":

____
____

5. We are required to report all claims for injuries to The Centers for Medicare/Medicaid Services (CMS). Are you a Medicare/Medicaid Beneficiary ? Check one: Yes No
If yes, please provide your Medicare or Medicaid claim number: ___________________________

6. Name and address of the owner of any damaged property:
____

7. Names, addresses, and phone numbers of all witnesses:
a. ____
b. ____
c. ____

8. Any additional information that might be helpful in investigating your claim:
____

9. If you have incurred damages, please enclose an estimate of repair costs, photos, and/or medical bills for consideration at this time.

WARNING: **It is a criminal offense to file a false claim (ORS 162.085)**
I have read the matters and statements made in the above claim and I know the same to be rue of my own knowledge, except as to those matters stated upon information of belief an as to such matters, I believe the same to be true. I certify under penalty of perjury that the foregoing is TRUE and CORRECT.

Signed this ____________ day of __________ , at _____ o'clock

____
Claimant's Signature