

CLAIM FOR DAMAGES TO PERSON OR PROPERTY

RESERVE FOR FILING STAMP

CLAIM No. _____

INSTRUCTIONS

1. Claims for death, injury to person or to personal property must be filed not later than 6 months after the occurrence. (Gov. Code Sec. 911.2)
2. Claims for damages to real property must be filed not later than 1 year after the occurrence. (Gov. Code Sec. 911.2)
3. Read entire claim before filing.
4. See page 2 for diagram upon which to locate place of accident.
5. This claim form must be signed on page 2 at bottom.
6. Attach separate sheets, if necessary, to give full details. SIGN EACH SHEET.
7. Claim must be filed with City Clerk. (Gov. Code Sec. 915a)

TO: CITY OF VERNON CITY COUNCIL

Name of Claimant

Age of Claimant (if natural person)

Home Address of Claimant

City and State

Home Telephone Number

Business Address of Claimant

City and State

Business Telephone Number

Give address to which you desire notices or communications to be sent regarding this claim:

How did DAMAGE or INJURY occur? Give full particulars.

When did DAMAGE or INJURY occur? Give full particulars, date, time of day:

Where did DAMAGE or INJURY occur? Describe fully, and locate on diagram on reverse side of this sheet, where approximate, give street names and address and measurements from landmarks:

What particular ACT or OMISSION do you claim caused the injury or damage? Give names of City employees causing the injury or damage, if known:

What DAMAGE or INJURIES do you claim resulted? Give full extent of injuries or damages claimed:

What AMOUNT do you claim of each item of injury or damage as of date of presentation of this claim, giving basis of computation:

Give ESTIMATED AMOUNT as far as known you claim on account of each item of prospective injury or damage, giving basis of computation:

Insurance payments received, if any, and name of Insurance Company:

Expenditures made on account of accident or injury: (Date - Item)

(Amount)

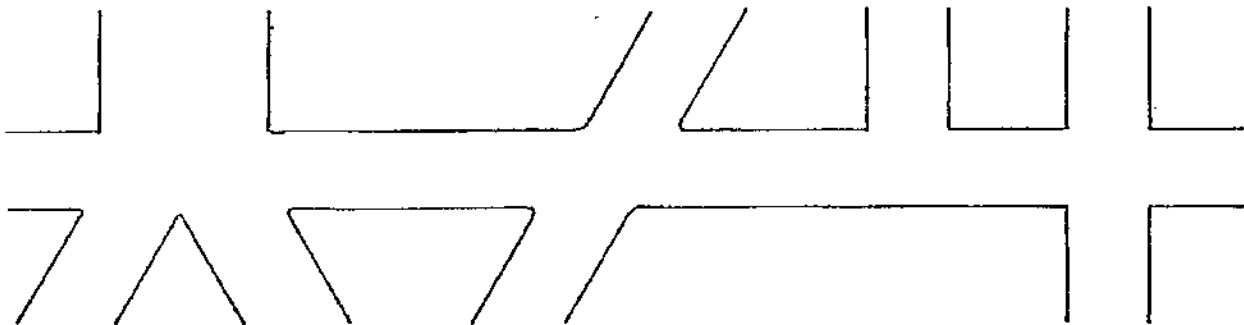
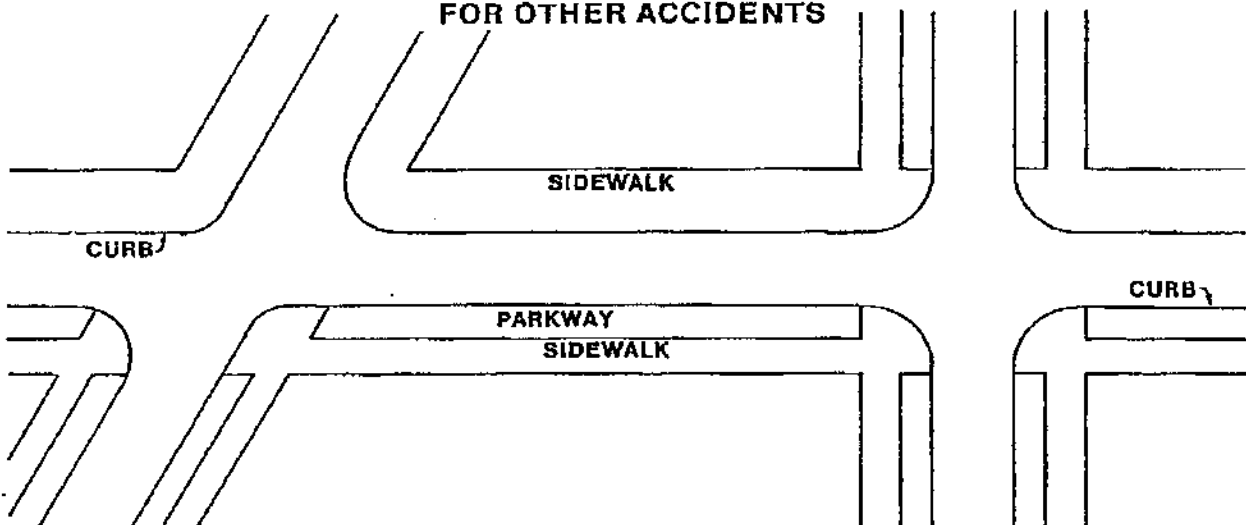
Name and address of Witnesses, Doctors and Hospitals:

READ CAREFULLY

For all accident claims place on following diagram names of streets, including North, East, South, and West; indicate place of accident by "X" and by showing house numbers or distances to street corners.

If City Vehicle was involved, designate by letter "A" location of City vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City vehicle; location of City vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of accident by "B-1" and the point of impact by "X."

NOTE: If diagrams do not fit the situation, attach hereto a proper diagram signed by claimant.

FOR AUTOMOBILE ACCIDENTS**FOR OTHER ACCIDENTS**

Signature of Claimant or person filing on his behalf, giving relationship to Claimant:

Typed Name:

Date:

NOTE: All claimants may be required to be examined as to their claim under oath. Presentation of a false claim is a felony. CLAIMS MUST BE FILED WITH CITY CLERK (GOV. CODE SEC. 915a).

01.20/2003 19:00

714-620-0645

ST PAUL INSURANCE CO

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SEND CLAIM TO:
DEPT. OF WATER & POWER
P.O. BOX 31111 ROOM 14
ATTN: CLAIMS SECTION
LOS ANGELES, CA 90031-1111

CLAIM TO DEPT. OF WATER & POWER

1	NAME _____	BIRTHDATE _____
1	ADDRESS _____	CITY, STATE & ZIP _____
	MAILING ADDRESS (For correspondence regarding this claim) _____	HOME PHONE NO. () _____
	CITY, STATE & ZIP _____	WORK PHONE NO. () _____
2	WHERE DID THE INCIDENT HAPPEN? _____	
	DATE OF INCIDENT _____	
	TIME OF INCIDENT _____	
3	DESCRIBE THE INCIDENT (Use back of form and additional sheets, if necessary) _____ _____ _____ _____	
4	DESCRIBE THE DAMAGE/INJURY/LOSS _____ _____ _____	
5	AMOUNT OF CLAIM \$ _____	
	NOTE: ENCLOSE SUPPORTING DOCUMENTS; Bills, Estimates, Invoices, Photos, etc.	
6	POLICE REPORT TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	POLICE DEPARTMENT (if Applicable) _____
		REPORT NUMBER _____
	WITNESSES TO THE INCIDENT (Use back of form if necessary)	
7	NAME _____	
	ADDRESS _____	CITY, STATE & ZIP _____
		HOME PHONE NO. () _____
8	NAMES OF DWP EMPLOYEES INVOLVED (if known) _____	
	DWP VEHICLE OR EQUIPMENT (if Applicable) _____	MAKE _____
	COLOR _____	VEHICLE NUMBER _____
		LICENSE NUMBER _____
9	YOUR VEHICLE (if Applicable) _____	YEAR _____
	MAKE _____	COLOR _____
	MODEL _____	LICENSE NUMBER _____
10	SIGNATURE _____ DATE _____	

NOTICE: YOU HAVE 6 MONTHS TO FILE A CLAIM FOR DEATH, PERSONAL INJURY, OR DAMAGE TO PERSONAL PROPERTY, AND 1 YEAR TO FILE A CLAIM FOR DAMAGE TO REAL PROPERTY OR FOR ANY OTHER TYPE OF INCIDENT.