INSTRUCTIONS FOR FILING CLAIMS

If you are seeking compensation from the **Kalkaska County Road Commission** for bodily injury or property damage, please complete the enclosed Claim Form and return it (with any attachments) to the address below. Your claim will then be reviewed by our claims administrator for processing.

Michigan County Road Commission
Self-Insurance Pool
Claims Department
PO Box 15067
Lansing, MI 48901

Claims filed with the Kalkaska County Road Commission are decided on a case-by-case basis by the claims administrator, and are adjudicated based on Michigan state laws. The Kalkaska County Road Commission has no authority to independently settle claims.

If your claim for damages arises from an alleged defect in a road under the jurisdiction of the Kalkaska County Road Commission, you must comply with *all* provisions of the attached statute, MCL691.1404. Failure to fully comply with all provisions of the statute will result in the denial of your claim.

CLAIM FORM

So that we may properly evaluate your claim, please complete the "General" information section and any following sections that apply. Please be as descriptive as possible. (Completion of this form does not imply that your claim will be paid or that the Road Commission is liable for your damages.)

GENERAL

NAME: ______

ADDRESS: ______ **CITY:** ______

STATE: ______ **ZIP CODE:** ______ **PHONE: (HOME):** ______ **(WORK):** ______

COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED: ______

IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER: ______

DATE & TIME OF ACCIDENT/INCIDENT: ______

LOCATION OF ACCIDENT/INCIDENT: ______

POLICE NOTIFICATION? YES ☐ **NO** ☐ **COMPLAINT NUMBER:** ______

DESCRIPTION OF ACCIDENT/INCIDENT: ______

WITNESSES: YES ☐ **NO** ☐ **(If so, provide name, address, and telephone numbers on back of this form.)**

INJURY

INJURED? YES ☐ **NO** ☐ **(If yes, please describe):** ______

MEDICAL FACILITY PROVIDING TREATMENT: ______

ARE YOU TREATING NOW? YES ☐ **NO** ☐

HAVE YOU LOST ANY TIME FROM WORK?: YES ☐ **NO** ☐ **(If yes, how long?):** ______

NAME, ADDRESS, PHONE NUMBER OF EMPLOYER: ______

DATE RETURNING TO WORK: ______

AUTO

AUTOMOBILE INVOLVED: MAKE: ______ **MODEL:** ______ **YEAR:** ______

DESCRIBE DAMAGE: ______

ATTACH (2) ESTIMATES: SHOP #1 EST. $ ______ **SHOP #2 EST. $** ______

AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier): ______

AGENT'S NAME: ______ **POLICY #:** ______

COLLISION COVERAGE: YES: ☐ **NO:** ☐ **DEDUCTIBLE $** ______

COMPREHENSIVE COVERAGE: YES: ☐ **NO:** ☐ **DEDUCTIBLE $** ______

HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES: ☐ **NO:** ☐

IS THERE A LIEN ON THIS VEHICLE?: YES: ☐ **NO:** ☐

PROPERTY

DESCRIBE PROPERTY DAMAGE: ______

ATTACH (2) ESTIMATES: EST. #1 $ ______ **EST. #2 $** ______

HOMEOWNER'S/COMMERCIALPROPERTY COVERAGE: YES ☐ **NO** ☐ **DEDUCTIBLE $** ______

INSURANCE CARRIER: ______

NAME, ADDRESS, PHONE NUMBER & AGENT'S NAME: ______

______ **POLICY #:** ______

SIGNATURE: ______ DATE: ______
(Required)

NOTE: A police report and a copy of your insurance declaration page (showing policy dates and coverages pertinent to accident date) are required if applicable to your claim. Information requested on this form that you fail to provide will cause delay in the processing of your claim. Please allow 3 to 4 weeks for handling of this claim.