CLAIM AGAINST THE STATE OF NEVADA

TO: **Claims Manager**
Office of the Attorney General
100 North Carson Street
Carson City, NV 89701-4717
(775) 684-1252 or (775) 684-1263

Received By AG's Office: *For AG's Office Use Only:*

Claim # _____ Dir. _____
X-Ref _____ Emp. _____
DOL _____ State Veh Lic _____
Cat _____ $ _____
B/A _____ Adj _____
Agency _____ due _____

The following information is necessary to fairly evaluate your claim. Please provide complete information. If you need more space, attach a separate sheet of paper. Additional evidence, such as photographs, police reports, etc., should be attached if available. However, such additional evidence will not be returned. Keep copies for your records. PLEASE PRINT LEGIBLY OR TYPE. You must sign the claim form.

YOU ARE NOT REQUIRED TO MAKE A CLAIM PRIOR TO FILING A LAWSUIT. THE MAKING OF A CLAIM WILL NOT STOP THE RUNNING OF THE APPLICABLE STATUTE OF LIMITATIONS.

- *You* are the claimant if you are making this claim for yourself.
- *Your Client* is the claimant if you are an attorney making a claim on behalf of a client.
- *Your Company* is the claimant if you are making a claim on behalf of a business.
- *The Insurance Company* is the claimant if you represent an insurance company.

1. CLAIMANT'S NAME _____

   ADDRESS _____

   _____

   Daytime TELEPHONE NUMBER: ( ) _____

   DATE OF BIRTH _____

2. **IF CLAIMANT IS A BUSINESS:** Name of Employee involved in incident _____

   Company Contact Person _____ Your Reference _____

3. **IF CLAIMANT IS AN INSURANCE COMPANY:** Name of your "INSURED" _____

   Claim Representative _____ Your Claim No. _____

4. **IF YOU ARE REPRESENTED BY AN ATTORNEY:** We will only communicate with you through your attorney. It is not necessary to retain an attorney to file a claim; however, if you have an attorney *for this claim*, please provide the following information:

   Attorney's Name _____

   Firm's Name _____ Tax I.D. Number _____

   Address _____

   _____

   Phone Number: ( ) _____ File Reference _____

5. DATE AND TIME when the incident occurred: _____

6. Exact LOCATION where the incident occurred: _____

7. **IF THIS IS AN AUTOMOBILE ACCIDENT, please supply the following information:**

   YOUR VEHICLE

   Year _____ Make _____ Model _____ License Number _____

   STATE VEHICLE

   Year _____ Make _____ Model _____ License Number _____

8. State the full names, addresses and phone numbers of all witnesses:

_____

_____

_____

9. **A CLAIM FOR $**_____ is hereby made against the STATE OF NEVADA, based upon the following facts:

10. Describe how damage or injury occurred and what the STATE OF NEVADA or its employees did to cause your damage or injury. **Give full details:**

_____

_____

_____

_____

_____

A) State of NV Employee's Name _____ B) State of NV Agency _____

11. Explain and support the amount of damages you have claimed by listing each item of damages. Please provide a **MINIMUM OF 2 REPAIR ESTIMATES** for property damage. Also include any rental bills, receipts, medical reports, itemized statements, etc.

_____

_____

_____

12. If this claim is for personal injury and/or payment of medical expenses you must answer this question: **Are you covered under any type of Medicare Program. NO** ____ **YES** ____ if yes: Pursuant to Federal Medicare rules, if liability is accepted by the State of NV, you will be required, at a later date, to provide your Medicare Health Insurance Claim Number (HICN).

I, _____, do hereby attest under penalty of perjury that I am the claimant named above, that I have read the foregoing claim and know the contents thereof, that the same is true of my own knowledge, except those matters stated upon information and belief, and as to those matters, I believe them to be true, and that THIS IS MY ENTIRE CLAIM AGAINST THE STATE OF NEVADA.

IF MY CLAIM IS PAID, I FULLY UNDERSTAND THAT I WILL HAVE TO SIGN A GENERAL RELEASE OF ALL CLAIMS IN THE PRESENCE OF A NOTARY PUBLIC FOR THE EXACT AMOUNT I AM CLAIMING BEFORE ANY PAYMENT WILL BE OFFERED TO ME. THIS RELEASE WILL BECOME EFFECTIVE ONLY UPON ACTUAL PAYMENT OF THE CLAIM BY THE STATE OF NEVADA.

_____ _____

Signature of Claimant (or Company Representative) Date

NOTICE: 197.160 of Nevada Revised Statutes provides that every person who knowingly presents a false claim is guilty of a gross misdemeanor, and is subject to criminal penalties of imprisonment of up to one year, and a fine of up to $2,000.

Incomplete or unsigned claim forms will not be accepted and will be returned.

Claims may be submitted as follows:

Fax: 775-684-1108 or

Mail:
Claims Manager
100 N Carson Street
Carson City NV 89701