Mail completed form to:

Department of the Corporation Counsel
530 South King Street, Room 110
Honolulu, HI 96813
corclaims@honolulu.gov

# CLAIM FORM

FOR OFFICE USE ONLY

Claim No.

**INSTRUCTIONS**

- This claim will not be processed unless filled in completely. **Please be as detailed and thorough as possible -** use additional paper for descriptions if necessary. Complete in ink.
- Submit claim form with **any and all** supporting documentation.
  - Photos – area of occurrence, damages, injuries, etc.
  - Invoices – *Damages*: receipts or at least two estimates for repair; *Injuries*: medical reports and/ or bills
  - Copy of registration and insurance card (vehicle damage)
  - Police report number (if any)

**Claims take approximately six (6) months to process.**

## CLAIMANT INFORMATION

Claimant Name: _____
*Last* *First* *M.I.*

Residence Address: _____
*Street Address* *Apartment/Unit #*

_____
*City* *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email: _____

Occupation: _____

## OCCURRENCE DESCRIPTION

Date of Occurrence: _____ Time of Occurrence: _____ Amount of Claim: _____

Location/ Address of Occurrence: _____

_____

_____

Description of Injury/ Damage: _____

How Injury/ Damage Occurred: _____

_____

_____

## ADDITIONAL INFORMATION

Witness(s) to Accident/ Injury:

| Name | Address | Phone No. |
|---|---|---|
| | | |
| | | |
| | | |

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) Section 111, requires the reporting of the following information.

Are you a Medicare beneficiary, or entitled to Medicare benefits? YES ☐ NO ☐

Are you currently receiving benefits? YES ☐ NO ☐

If the answer to the above question is YES, the following information must be provided:

Social Security No.: _____ Date of Birth _____ MALE ☐ FEMALE ☐

**NOTICE:**
**Filing a false claim is a violation of Hawaii Revised Statutes §46-171, et seq., and could result in a civil penalty of not less than $5,000 and not more than $10,000, plus treble damages.**

**BY SIGNING THIS FORM, I HEREBY CERTIFY THAT THE INFORMATION AND CLAIM SUBMITTED ARE TRUE AND CORRECT**

Dated: _____

_____
SIGNATURE OF PERSON FILING CLAIM