Kentucky Claims Commission General Instructions

130 Brighton Park Blvd. * Frankfort, Kentucky * 40601 * 502-782-8255 office

You must use ink or type the information. Although no filing fee is charged, the original signed claim form with all evidence attached is required. One copy of the claim form and evidence may also be submitted with the original. If an attorney is involved, the claimant and the attorney must sign the claim form. The Board only accepts claims of $100 or above. The maximum award shall not exceed a single individual award of $200,000 and multiple claims shall not exceed a total award of $350,000.

Section I. Information about the claimant only.

Section II Name the State agency involved.

Section III. The name of the person that referred you to the KY Claims Commission.

Section IV. Date and time of the incident. Must be filed within one year.

Section V. Provide incident information. **Be specific**.

Section VI. Give a complete incident description

Section VII Describe completely how the state agency or employee was at fault.

Section VIII. State the exact dollar amount of your claim and include itemized receipt(s), OR at least two repair estimates for damages

Section IX. Complete this section if a motor vehicle was involved, with a copy of the police report. You must submit a copy of your insurance card or declaration sheet.

Personal Injuries must be supported with proper documentation, insurance policy numbers, effective dates etc. Other damage must be supported with proper insurance information, policy number, effective dates and deductible.

The KY Claims Commission requires the original claim form. NO FAXED CLAIMS will be investigated. Although a claim form may be faxed for purposes of filing within the statute of limitations, the original must be submitted before the claim will be investigated.

No claims can be granted for the following:

- Claims under $100.
- Claims for pain and suffering.
- Collateral, dependent or subrogation claims.
- Claims where a state agency has no jurisdiction (i.e., areas or events where legal responsibility lies with contracted entities or non-state agencies).

YOU MUST SIGN as the claimant and you MUST provide your Social Security or Federal ID before your claim can be investigated or submitted for a hearing.

Commonwealth of Kentucky
Public Protection Cabinet
Kentucky Claims Commission
130 Brighton Park Boulevard
Frankfort, Kentucky 40601
Telephone: (502) 782-8255
Fax: (502) 573-4817

CLAIM FORM

COMPLETE ALL SECTIONS THAT APPLY TO YOUR SPECIFIC CLAIM

Through KRS 44.070, the Kentucky Claims Commission is vested with authority to compensate persons for damages sustained to person or property as a result of **negligence** on the part of the Commonwealth. The burden of proof that the Commonwealth was negligent rests with you. **The Kentucky Claims Commission will not find the Commonwealth negligent simply because an incident occurred on state property; fault must be found.** Negligence must be proven before an award can be made. Please provide all facts, statements by witnesses (in writing), or any other proof you have that you believe would be helpful in the determination of your claim.

Claims for damages must be at least One Hundred Dollars ($100.00) and the **original** claim form must be submitted.

I._____
Claimant's Name Address

_____
City, State and Zip Code

(____)_____ (____)_____
Daytime telephone number Mobile telephone number

_____
Email address

II._____
Name of State Agency involved with the incident (employee's name, if known)

III. Who referred you to the KY Claims Commission?_____

IV._____
Date and time of the incident (all claims shall be filed within one year of incident)

V. _____** County_____
Location where the incident occurred. Please provide **exact** location including **direction (North, South, East or West)**, **mile marker**, **name** or **number of road**, **intersection**, etc. **PLEASE BE SPECIFIC** so that your claim may be thoroughly investigated.

VI. Describe the incident and the damage done to you or your property.

_____

_____

_____

_____

_____

_____

VII. In what way do you believe the state agency or employee was at fault? What more could the state have done?

_____

_____

_____

VIII. State the specific dollar amount of your claim. Submit bills, receipts and/or **TWO** repair estimates as proof of the cost of damages sustained. **This amount will be amended according to the amount you can recover from insurance**. $_____

IX. If motor vehicles were involved, please complete the following:

STATE VEHICLE:

Tag number, if known_____

Driver, if known _____

CLAIMANT'S VEHICLE: **(This claim must be filed and signed by the registered owner.)**

In whose name is the vehicle registered? _____

Vehicle year, make and model: _____

Name and address of driver and passengers:

_____

_____

Name of law enforcement authority or officer who investigated the incident: _____

_____

Please submit a copy of police report, incident report, or Uniform Traffic Report if possible.

Pursuant to KRS 44.070, the Commission can only award what claimant cannot recover through insurance or any other source. The Commission must reduce any award by what amount the claimant has a right to receive from any insurance coverage. In order to review your claim as submitted, provide all information below that relates to the damages you incurred.

Please submit a copy of your insurance card or declaration sheet.

VEHICLE INSURANCE

1) Insurance Agent and Address: _____

_____

Telephone #:_____

2) Insurance Company: _____

Policy Number: _____

Effective Dates: _____

3) Collision Coverage in Effect: ( )Yes ( )No Amount of Deductible $ _____

4) Comprehensive Coverage in Effect: ( )Yes ( )No Amount of Deductible $_____

5) Liability Coverage only: ( )Yes ( )No

PERSONAL INJURY INSURANCE

6) Hospitalization Insurance in Effect: ( )Yes ( ) No Dental Insurance in Effect: ( ) Yes ( ) No

Name of Insurance Company: _____

Policy Number: _____ Effective Dates: _____

Amount of Deductible: _____ Has this deductible been met for the year?( )Yes ( )No

7) Compensation Insurance Coverage in Effect: ( )Yes ( )No

Name of Company: _____

Policy Number: _____ Effective Dates: _____

Deductible: _____ Has this deductible been met yet for this year? ( )Yes ( )No

8) If you have any other insurance coverage that would entitle you to recover the damages which are the subject of your claim, please list what type and the amount of the deductible if any.

_____

OTHER INSURANCE

9) Homeowner _____ Dwelling _____ or Mobile Home Coverage _____

Name of Company: _____

Policy Number: _____ Effective Dates: _____

Deductible: _____ Has this deductible been met yet this year? ( )Yes ( )No

10) If you have any other insurance coverage that would entitle you to recover the damages which are the subject of your claim, please list what type and the amount of the deductible if any.

_____

_____

_____

YOU MUST SIGN : Claimant's Signature:_____

Address: _____

Daytime Telephone: _____(work)Telephone:_____

Mobile Telephone:_____

Date: _____

WE MUST HAVE: Social Security Number or Federal ID Number: _____

Attorney's Name:_____

Attorney's Signature:_____

(*if represented by Counsel*)

Address:_____

Telephone:_____Date:_____

Federal ID Number:_____

Claim must be presented to the Kentucky Claims Commission within one year from the date of the incident.