



CITY OF SEWARD NEBRASKA
 537 MAIN ST
 PO BOX 38
 SEWARD, NE 68434-0038

PH: 402-643-2928
 FAX: 402-643-6491

CLAIM FORM

CONTACT INFORMATION

Name: _____ Home Phone: _____
 Address: _____ Business Phone: _____
 Date & Time of Incident: _____ Cell Phone: _____
 Location of Incident: _____ Email: _____
 Type of Incident: Injured Person Property Damage Automobile Accident (Check all that apply)

INJURED PERSON

Occupation: _____ Employed by: _____
 Did you see a doctor? Yes No Doctor's Name: _____
 Were you hospitalized? Yes No Hospital: _____
 Describe incident (nature & extent of injury): _____

 Any Witnesses? _____

PROPERTY DAMAGE

List Property Damaged: _____
 Age of damaged property: _____ Estimated cost of repair: _____
 How was the property damaged? _____

AUTOMOBILE ACCIDENT

Driver, if other than owner: _____
 Address: _____ Home Phone: _____
 Estimated cost of repair: _____ Business Phone: _____
 Vehicle: (year, make, model) _____ Police Notified? Yes No
 Your description of the accident: _____

INSURANCE INFORMATION

Amount of Claim: _____ **(COPIES OF BILLS MUST BE ATTACHED VERIFYING AMOUNT OF CLAIM)**
 Your Insurance Company: _____ Your Insurance Agent: _____
 Insurance Company Phone: _____ Insurance Agent Phone: _____
 Did you report a claim? Yes No Did you receive payment? Yes No Deductible: _____

ADDITIONAL INFORMATION

Any other pertinent information: (write on back if more space needed) _____

 Explain why you feel the City of Seward is responsible: _____

SIGNATURE OF CLAIMANT: _____ DATE: _____