Board of Claims General Instructions

130 Brighton Park Blvd. * Frankfort, Kentucky * 40601 * 502-573-7986 office

Website:boc.ky.gov

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 Board of Claims.

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 with all bills and 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 Board of Claims 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
BOARD OF CLAIMS
130 Brighton Park Blvd.
Frankfort, Kentucky 40601
800-469-2120
502-573-7986

CLAIM FORM

COMPLETE THIS FORM IN INK OR TYPE
COMPLETE ALL SECTIONS THAT APPLY TO YOUR SPECIFIC CLAIM

Through KRS 44.070, the Board of Claims 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 Board of Claims 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 Board of Claims?_____

IV._____
Date and Time Incident Occurred (must be filed within one year)

V. _____** County_____
Where the Incident Occurred. Give **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. Supply 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:

In whose name is the vehicle registered? _____

** **This claim must be filed and signed by the registered owner.**

Vehicle year, make and model: _____
Name and address of driver and passengers:
_____

_____
Name and telephone number of office you called to get your claim form.

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 Board can only pay what claimant cannot recover through insurance or any other source. The Board must reduce any award by what amount the claimant has a right to receive from any insurance coverage. Please show proof that all bills have been submitted to your insurance company and provide exact amount of claimant's out –of-pocket expenses and amount not covered by insurance. 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 DAMAGE

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 only: ( )Yes ( )No

PERSONAL INJURY

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 your deductible been met this year?( )Yes ( )No

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

Name of Company: _____

Policy Number: _____Effective Dates: _____

Deductible: _____ Been Met? ( )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 DAMAGE

9) Homeowner _____Dwelling _____or Mobile Home Coverage _____

Name of Company: _____

Policy Number: _____ Effective Dates: _____

Deductible: _____ Been Met? ( )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 Signature:_____
(*if represented by Counsel*)
Address:_____
Telephone:_____Date:_____
Federal ID Number:_____

Claim must be presented to the Board of Claims within one year from the date of the incident.
IF CLAIMANT IS A CORPORATION THEN CLAIM MUST BE FILED BY AN ATTORNEY LICENSED IN THE STATE OF KENTUCKY.