Mail completed form to:

Department of the Corporation Counsel
1001 Bishop Street, Suite 2020
Honolulu, HI 96813
corclaims@honolulu.gov

FOR OFFICE USE ONLY

Claim No.

# NOTICE OF CLAIM

- The information provided here does not constitute legal advice. You should consult a legal professional at your own cost if you require legal assistance.
- With very limited exceptions, no lawsuit for money damages may be brought against the City or its employees unless a Notice of Claim is filed with the Corporation Counsel. The Notice of Claim acts as a prerequisite for filing a lawsuit against the City, seeking recovery for damages related to injuries to persons or property. Please refer to the following legal provisions: Honolulu Revised Charter of the City and County of Honolulu (Section 13-111) and Hawai'i Revised Statutes (Section 46-72). Hawai'i law requires any lawsuit based on the incident described in your claim to be filed within two years from the date of that incident. Submitting your claim does not extend this two-year statute of limitations for filing a lawsuit. Even if your claim is denied or not acted upon, the two-year period remains unchanged.
- Filing a Notice of Claim does not automatically guarantee compensation or investigation. The Corporation Counsel has the discretion to investigate your claim. If deemed appropriate, you may receive compensation based on the investigation results.
- 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 completed claim form with **any and all** supporting documentation; add attachment if necessary.
  - 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)

## 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 ☐

**Filing a false claim is a violation of Hawai'i Revised Statue §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