INSTRUCTIONS FOR FILING CLAIMS

If you are seeking compensation from the Marquette County Road Commission for bodily injury or property damage, please complete the enclosed Claim Form and return it (with any attachments) to the address below. Your claim will then be reviewed by our claims administrator for processing.

Michigan County Road Commission
Self-Insurance Pool
Claims Department
PO Box 1825
Grand Rapids, MI 49501

Claims filed with the Marquette County Road Commission are decided on a case-by-case basis by the claims administrator, and are adjudicated based on Michigan state laws. The Marquette County Road Commission has no authority to independently settle claims.

If your claim for damages arises from an alleged defect in a road under the jurisdiction of the Marquette County Road Commission, you must comply with *all* provisions of the attached statute, MCL691.1404. Failure to fully comply with all provisions of the statute will result in the denial of your claim.

LOSS FORM

So that we may properly evaluate your loss, please complete the "General" information section and any following sections that apply. Please be as descriptive as possible and attach additional pages, if necessary. This form is for administrative purposes only and should not be construed as legal advice. Completion of this form does not imply that you will be compensated for your loss or that the Road Commission is liable for any asserted damages. This form does not constitute, substitute for, or replace any legal notice required by any statute or law in the State of Michigan, whether contained in the Governmental Tort Liability Act, MCL 691.1401, et seq., or otherwise. By accepting this form, the Road Commission does not waive any defense available to it under the laws of the State of Michigan.

GENERAL

NAME: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE: (HOME): _____ (WORK): _____

COUNTY IN WHICH ACCIDENT/INCIDENT OCCURRED: _____

IF A COUNTY VEHICLE WAS INVOLVED, PROVIDE VEHICLE NUMBER: _____

DATE & TIME OF ACCIDENT/INCIDENT: _____

LOCATION OF ACCIDENT/INCIDENT: _____

POLICE NOTIFICATION? YES _____ NO _____ COMPLAINT NUMBER: _____

DESCRIPTION OF ACCIDENT/INCIDENT: _____

_____

_____

WITNESSES: YES _____ NO _____ (If so, provide name, address, and telephone numbers on back of this form.)

INJURY

INJURED? YES _____ NO _____ (If yes, please describe): _____

_____

_____

MEDICAL FACILITY PROVIDING TREATMENT: _____

ARE YOU TREATING NOW? YES _____ NO _____

HAVE YOU LOST ANY TIME FROM WORK?: YES _____ NO _____ (If yes, how long?): _____

NAME, ADDRESS, PHONE NUMBER OF EMPLOYER: _____

_____

DATE RETURNING TO WORK: _____

AUTO

AUTOMOBILE INVOLVED: MAKE: _____ MODEL: _____ YEAR: _____

DESCRIBE DAMAGE: _____

_____

ATTACH (2) ESTIMATES: SHOP #1 EST. $ _____ SHOP #2 EST. $ _____

AUTO INSURANCE INFORMATION (Name, Address, Phone Number of Carrier): _

_____

AGENT'S NAME: _____ POLICY #: _____

COLLISION COVERAGE: YES: _____ NO: _____ DEDUCTIBLE $ _____

COMPREHENSIVE COVERAGE: YES: _____ NO: _____ DEDUCTIBLE $ _____

HAS CLAIM BEEN REPORTED TO YOUR CARRIER?: YES: _____ NO: _____

IS THERE A LIEN ON THIS VEHICLE?: YES: _____ NO: _____

PROPERTY

DESCRIBE PROPERTY DAMAGE: _____

_____

ATTACH (2) ESTIMATES: EST. #1 $ _____ EST. #2 $ _____

HOMEOWNER'S/COMMERCIAL PROPERTY COVERAGE: YES _____ NO _____ DEDUCTIBLE $ _____

INSURANCE CARRIER: _____

NAME, ADDRESS, PHONE NUMBER & AGENT'S NAME: _____

_____ POLICY #: _____

SIGNATURE: _____ DATE: _____
(Required)

NOTE: A police report and a copy of your insurance declaration page (showing policy dates and coverages pertinent to loss date) are required, if applicable. Failure to provide the information requested on this form will cause delay in the processing of your loss. Please allow 30 days for processing.

August 7, 2015