

**NOTICE OF TORT CLAIM**

**OKLAHOMA MUNICIPAL ASSURANCE GROUP (OMAG) – MUNICIPAL LIABILITY PROTECTION PLAN**

**A. CLAIMANT REPORT**

To the \_\_\_\_\_ City of Skiatook  
Public entity you are filing the claim against.

**PLEASE PRINT OR TYPE AND SIGN**

**IMPORTANT NOTICE:** This notice will be sent to OMAG Claims Dept. for investigation. You may expect them to contact you.

CLAIMANT(S) \_\_\_\_\_ CLAIMANT(S) SOCIAL SECURITY NO. \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CLAIMANT(S) DATE OF BIRTH \_\_\_\_\_ Circle: M F  
PHONE: HOME (\_\_\_\_) \_\_\_\_\_ BUS. (\_\_\_\_) \_\_\_\_\_

- (Exact Date Required) (Continue on another sheet if needed for any information requested)
- DATE AND TIME OF INCIDENT \_\_\_\_\_ (\_\_\_\_) a.m. (\_\_\_\_) p.m.
  - LOCATION OF INCIDENT \_\_\_\_\_
  - DESCRIBE INCIDENT \_\_\_\_\_

**4. LIST ALL PERSONS AND/OR PROPERTY FOR WHICH YOU ARE CLAIMING DAMAGES:**

**BODILY INJURY:** WAS CLAIMANT INJURED? YES \_\_\_ NO \_\_\_ If yes, complete this section  
Describe injury \_\_\_\_\_  
WERE YOU ON THE JOB AT THE TIME OF INJURY? YES \_\_\_ NO \_\_\_ If so, please provide Employer info.

Employer's Name	Address	Phone
		ALL MEDICAL BILLS (attach copies) \$ _____
		LIST OTHER DAMAGES CLAIMED \$ _____

**MEDICARE/MEDICAID/SOCIAL SECURITY DISABILITY:**  
Is there any Social Security Disability involvement \_\_\_ Yes \_\_\_ No  
Has any medical bill been paid or will be paid by Medicare/Medicaid? \_\_\_ Yes \_\_\_ No. If so, list Medicare/Medicaid Number.  
Medicare/Medicaid Number \_\_\_\_\_  
If the City is responsible for such bills, the City must report any settlement to Medicare/Medicaid.

I understand that the information requested is to assist the requesting insurance information arrangement to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligation under Medicare Secondary Payer Act 42 U.S.C§1395y.

\_\_\_\_\_  
Medicare/Medicaid Beneficiary Name (please print) Medicare/Medicaid Beneficiary Name Signature

**PROPERTY DAMAGE:** Proof that you are the owner of the vehicle or property allegedly damaged as specified in your claim will be required.

VEHICLE YEAR \_\_\_\_\_ MAKE \_\_\_\_\_ MODEL \_\_\_\_\_

**NOTE: If damage is to a vehicle, a photocopy of your motor vehicle title is required.**

IF NOT A VEHICLE, DESCRIBE PROPERTY AND LOSS \_\_\_\_\_

PROPERTY DAMAGE (Attach repair bills or estimates if available) \$ \_\_\_\_\_  
LIST OTHER DAMAGES CLAIMED \$ \_\_\_\_\_

5. NAME OF YOUR INSURANCE CO.	POLICY NO.	AMOUNT CLAIMED	AMOUNT RECEIVED
_____	_____	\$ _____	\$ _____

6. The names of any witnesses known to you:

_____	_____	_____
Name	Address	Phone Number
_____	_____	_____
Name	Address	Phone Number

STATE THE EXACT AMOUNT OF COMPENSATION YOU WOULD ACCEPT AS FULL SETTLEMENT ON THIS CLAIM.  
TOTAL CLAIM.....\$ \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE(S) DATE

**B. THIS SECTION IS FOR USE BY THE PUBLIC ENTITY WHICH RECEIVES THE CLAIM**

To inquire about this claim you may write to OMAG Claims Dept. or call 1-800-234-9461

This Notice of Tort Claim was received by \_\_\_\_\_

(Title) \_\_\_\_\_, on \_\_\_\_\_, 20\_\_\_\_

For further information on this claim contact \_\_\_\_\_

(Title) \_\_\_\_\_, by telephone at (\_\_\_\_)

The following reports, statements or other documentation, which support our understanding of the facts relating to this claim are attached:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Information for City Owned Vehicle Involved:**

Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Last 4 Vin#: \_\_\_\_\_ Dept: \_\_\_\_\_

As a result of this incident, are there damages to the City vehicle? \_\_\_\_ YES \_\_\_\_ NO

If YES, please fill out an **OMAG Auto Loss Notice** to have it repaired.

Persons who have knowledge of the circumstances surrounding this claim are:

Name	Title/Position	Telephone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Submitted by: \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

Title: \_\_\_\_\_

**AFTER THE PUBLIC ENTITY HAS RECEIVED THIS CLAIM, PLEASE PROVIDE INFORMATION REQUESTED ABOVE AND IMMEDIATELY SEND TO:**

OMAG Claims Dept.  
3650 S. Boulevard  
Edmond, OK 73013  
Phone (405) 657-1400  
Fax (405) 657-1401  
[claimsdepartment@omag.org](mailto:claimsdepartment@omag.org)