CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED

UNION COUNTY COUNSEL
RECEIVED
MAR 10 2011
ADMINISTRATION BUILDING
ELIZABETH, NJ

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Athomasopoulos Demi
Last Name, First, Middle

Feb 8 1962
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

★: home address
Social Security#
home ph.#
VIN#
unListed
ph.#
Cell ph.#
credit card #/
Transaction codes
Driver's License#

3. The occurrence or accident which gave rise to this claim:

A. Date 1/27/11 Time 18:57

B. Describe the location or place of the accident or occurrence

Union County
Municipality

Raritan & Westfield
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

Car hit a very large pothole in the middle of the intersection

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (✓) Property Damage
( ) Other - Explain in detail_____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (✓) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

_____

Name of Employer Address of Employer

_____

Your Occupation Date of Employment

_____

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

_____ _____

LOCATION DATE TIME

C. Date property was acquired.

_____

D. Cost of property.

E. Value of property at time of accident.

_____

F. Description of damage.

2 flats + damaged rim - drivers side front

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

American tire | 1/02/11 | $150

Repaired by | When | Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

got an estimate for drivers side front of $700

B. The amount of the claim.

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union county -

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

11. State the names and address of all witnesses to the accident or occurrence.

Vincent DeGeorge
Name of Witness

[redacted]
Address

Name of Witness

Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Name of Police Officer

Clark Police
Police Department

Name of Police Officer

Police Department

B. Copy of Police Report attached:
( ) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

No

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

No

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 2-03-11

Claimant or person filing claim on behalf of claimant.

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (✓) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: _____ **Signature:** _____

no injuries
no medical
Preston

Document : INVOICE
Customer # : KONW6-0
Order # : 94231
Order Date : 02/02/11
Salesperson : Jeff Stiebritz
Department : 01
PO# :
Hand Ticket :

AMERICAN TIRE & AUTO CARE

2302 Route 516
Old Bridge, NJ 08857

(732) 679 - 6800
Visit us at www.americantires.net

AMERICAN TIRE & AUTO CARE VI

OLD BRIDGE

User: Will Dupree

44439

Invoice # : 44439
Invoice Date : 02/02/11

Vehicle:
License:
Mileage: 0
VIN #:
Year: 2007
Make: MERCEDES BENZ
Model: S550
Option: V8-5461 5.5L DOHC
Unit ID:
Comment:

REPRINT

Billing:
KONDIOLAS WILLIAM
[redacted]

[redacted]

			Description	Tech	Qty	Price	FET	Extende
03503840000	255/40R19	CON	Pro Contact XL BW 100V TL	None	2.0	$276.95	$0.00	$553.
WB			HIGH SPEED WHEEL BALANCE	RN	2.0	$12.95	$0.00	$25.
CWW			WITH COATED WHEEL WEIGHTS	RN	2.0	$0.00	$0.00	$0.
RH	TIRE PROTECTION POLICY	SVC	Tire Services	RN	2.0	$27.69	$0.00	$55.
TEF			TIRE ENVIRONMENTAL FEE	RN	2.0	$2.00	$0.00	$4.
NJ			NJ Motor Tire Fee	RN	2.0	$1.50	$0.00	$3.
DOT			DOT # AF5W N1H6 4610	RN	2.0	$0.00	$0.00	$0.
CPRH			COUPON	RN	-1.0	$276.95	$0.00	-$276.
JS								
SUB			RIM REPAIR (RIGHT FRONT)	None	1.0	$175.00	$0.00	$175.

I authorize the repair work set forth to be done with the necessary parts and materials. I hereby grant you and your employees permission to operate the vehicle herein described on streets, highways or elsewhere for the purpose of testing and/or inspection. I agree you are not responsible for vehicle damage beyond your control or any delays caused by unavailability of parts or delay in parts shipments by the supplier or transporter. All parts will be discarded unless otherwise specified. An express mechanic's lien is acknowledged on above vehicle to secure the amount of repairs and materials.

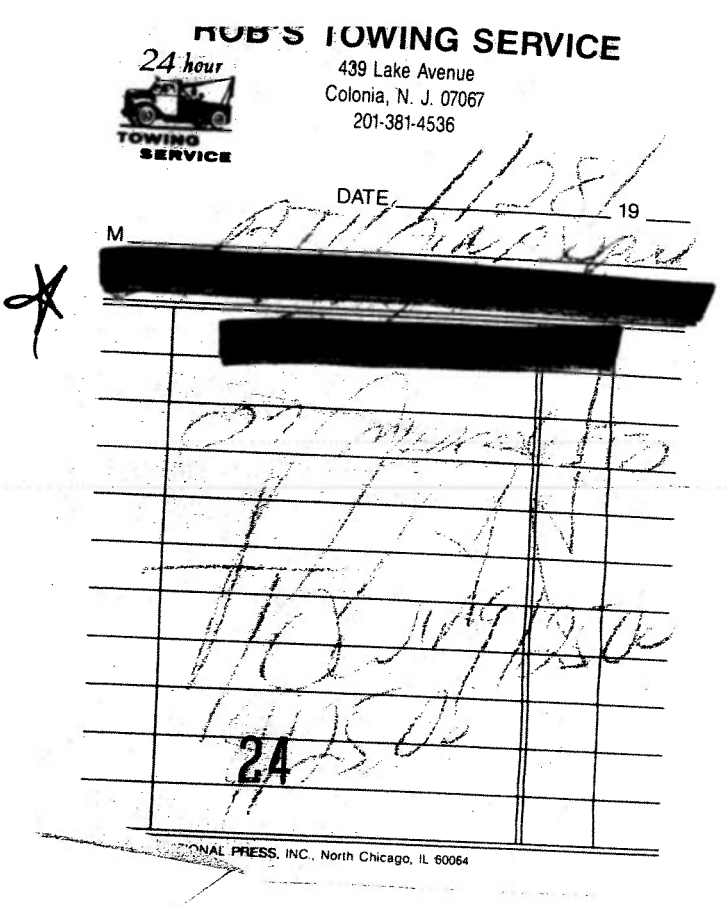
No disclaimer
No disclaimer

Sub Total:	$540
Tax Total:	$37
Total Due:	$577

Payments	Amounts
Visa/Mastercard	$577
Total Applied	**$577**
Amount Paid	$577
Change	$0

Terms	Due Dat
Paid in Full	N/A

CUSTOMER SIGNATURE: X_____



ROB'S TOWING SERVICE
24 hour
TOWING SERVICE
439 Lake Avenue
Colonia, N. J. 07067
201-381-4536

DATE 11/28/ 19

M [redacted]

24

NAL PRESS, INC., North Chicago, IL 60064

Clark Police Department

315 Westfield Avenue, Clark, NJ 07066
Phone: 732-388-3434 Fax: 732-388-5376 Mun. Code: 2002

CAD Ticket

Call #	Case #	Date	Time of Call	Arrived	Cleared	9-1-1
11-02402		01/27/11	18:57	19:03	19:27	☐

Vehicle	State	Code	Features	Warning
Y72AFV	NJ			☐

Incident Type	Business / School / Location Name
Property Damage (Non-Criminal)	

Street #	Street Name	Apt #	At/Intersection of
	Raritan Road		Westfield Avenue

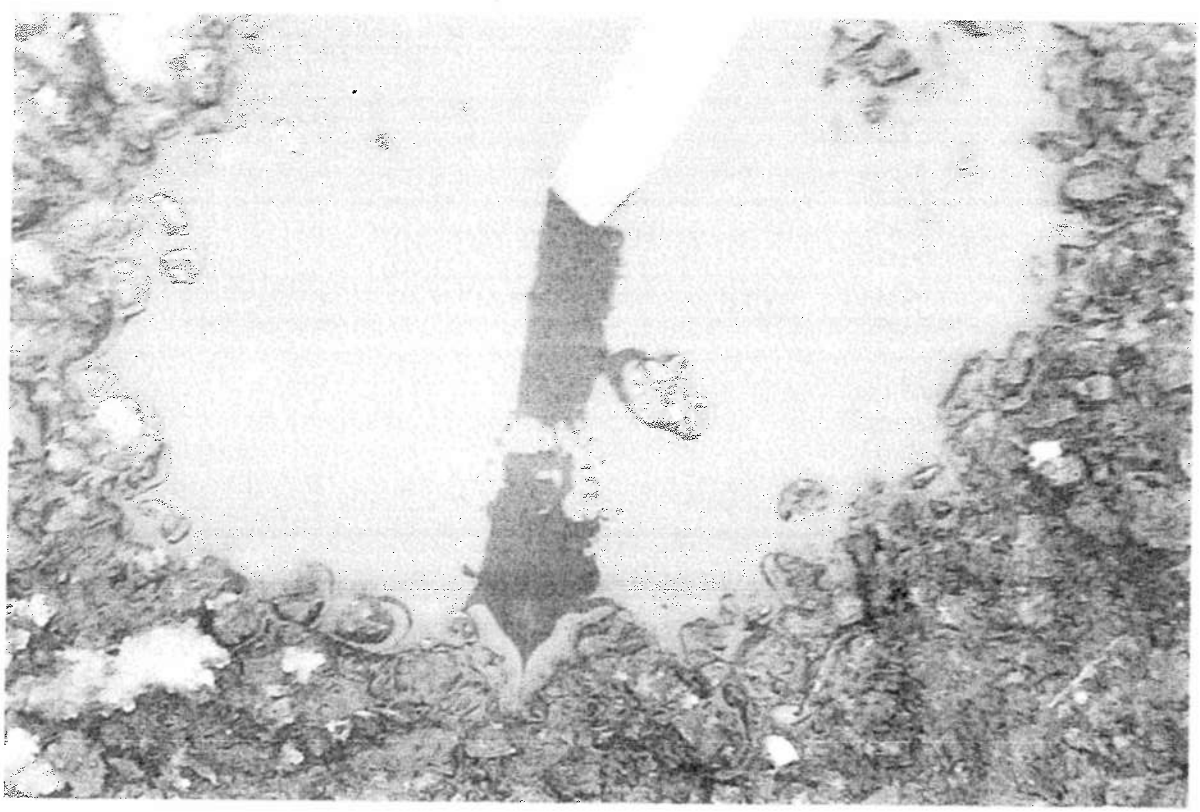
Caller (Lastname, Firstname)	Caller Address	Caller Phone
Athanasopoulos, Irini	[redacted]	[redacted]

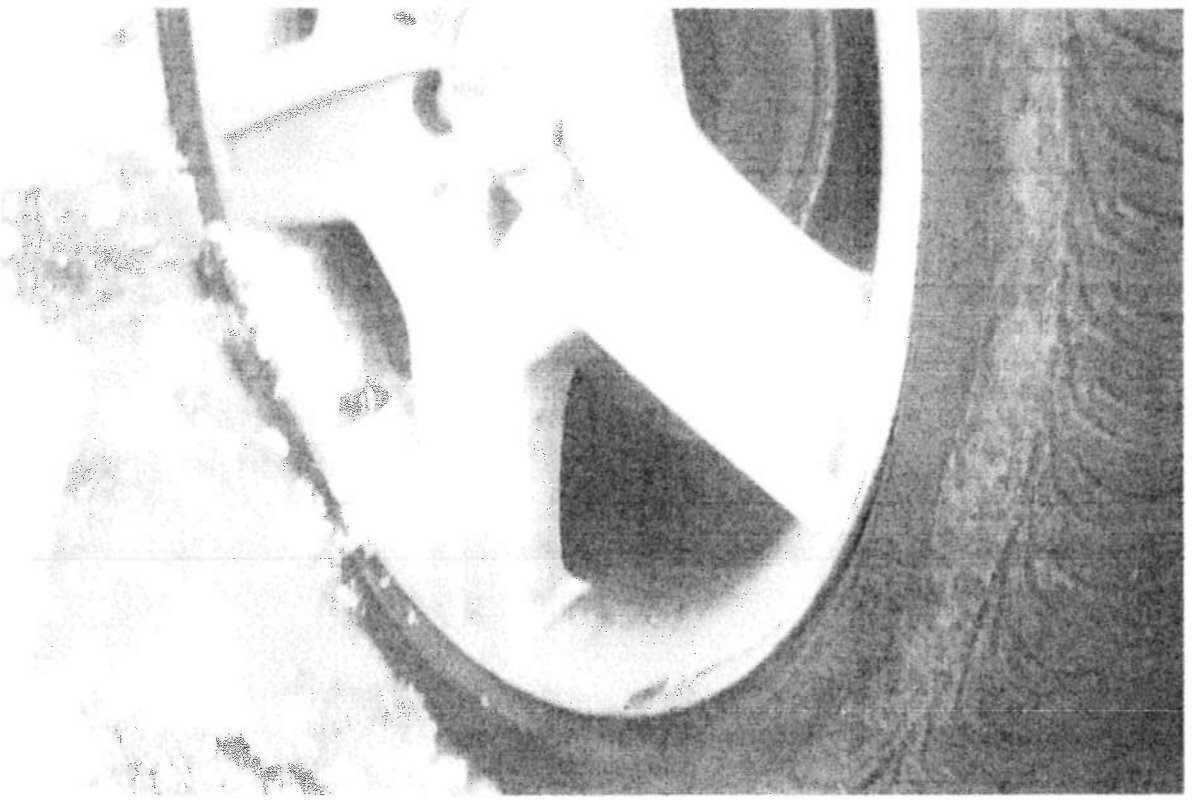
Notes:

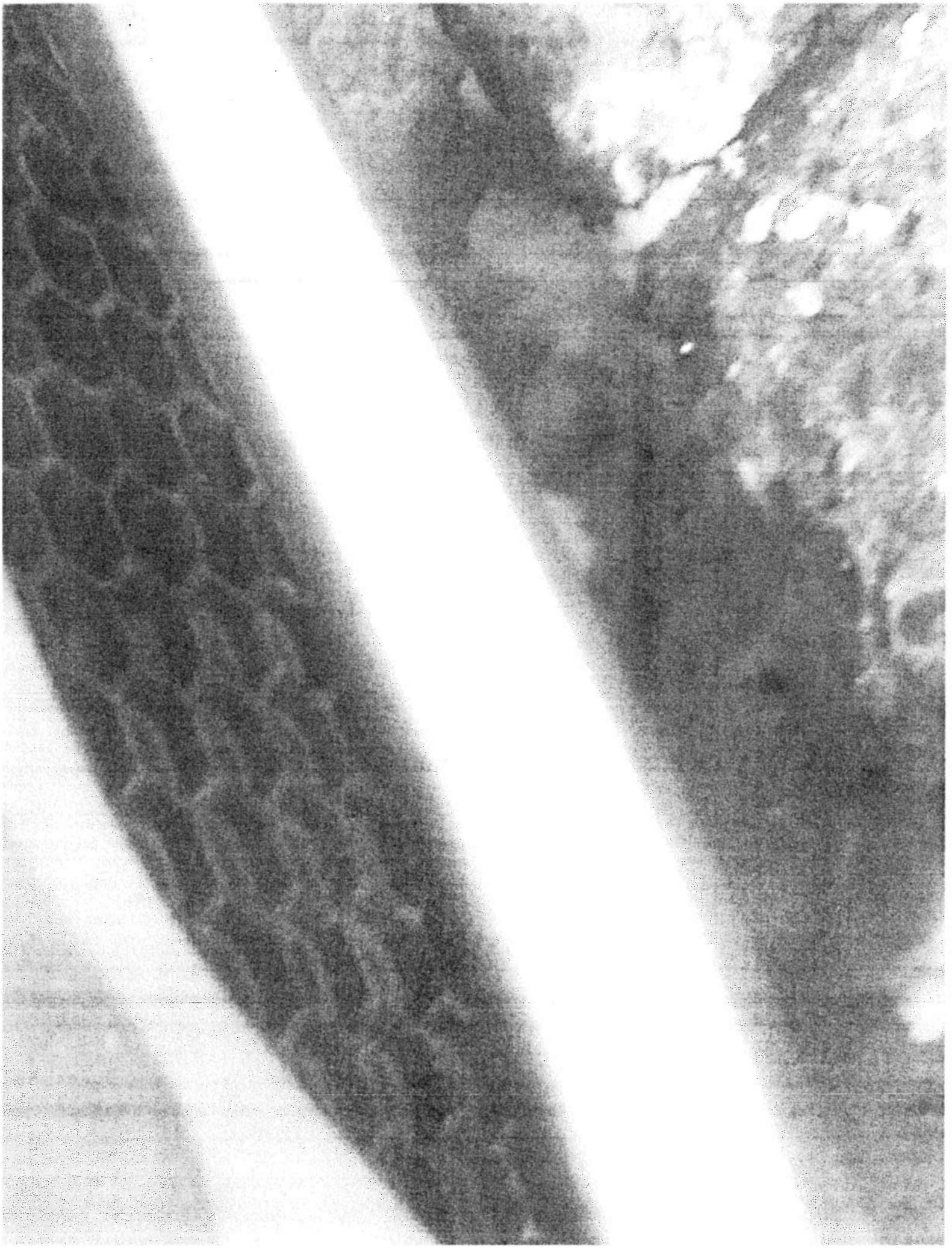
Both right side tires blown out from hitting a pot hole on Raritan Rd near Sovereign Bank. Operator provided with contact # for the Union County Police and advised to call the UC Road Dept concerning pot hole and damage to motor vehicle. ER/138

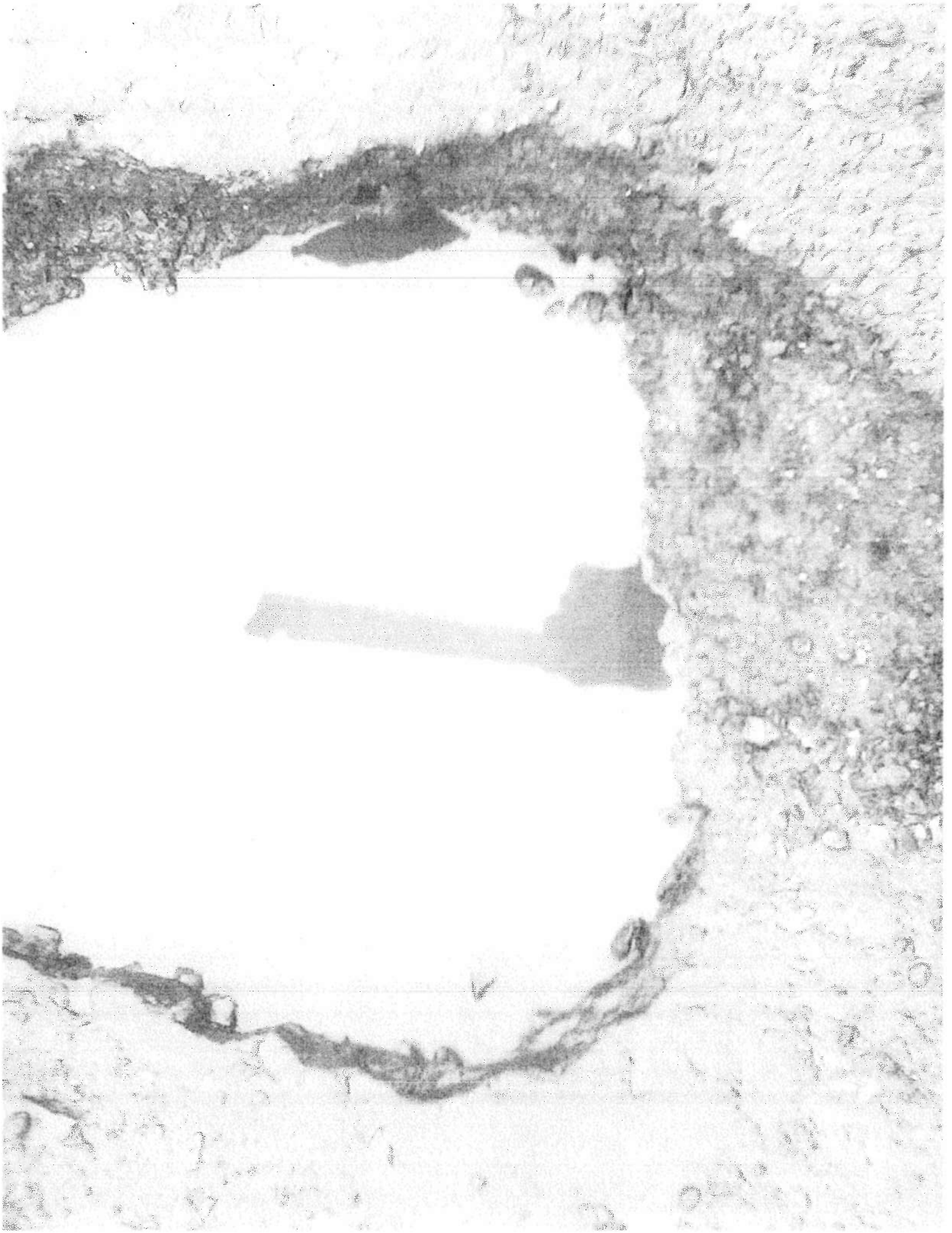
Officer(s)	Car(s)
Ptlm. Eric Richter 138	911

Dispatched By: vmacaluso









CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

AURIEMA MARIA —
Last Name, First, Middle

NOV. 16, 1948
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 12/27/10 Time 4:09 PM

B. Describe the location or place of the accident or occurrence

CLARK
Municipality

PARKWAY DRIVE
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

A TREE FELL ON MY CAR FROM THE WOODS IN RAHWAY RIVER PARK

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury ( ) Property Damage
(X) Other - Explain in detail I SEEK REIMBURSEMENT OF RENTAL CAR FROM ENTERPRISE, AND $200.00 DEDUCTIBLE, FROM INSURACE CO.

B. If you claim Personal Injury; NO

B1. Describe your injuries resulting from this accident or occurrence:

N/A

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (X) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state: N/A

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state N/A

Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss. N/A

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage: N/A

A. Describe the property damage:

B. The present location and time when the property may be inspected:.

LOCATION DATE TIME

C. Date property was acquired.

D. Cost of property.

E. Value of property at time of accident.

F. Description of damage.

_____

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

_____	_____	_____
Repaired by	When	Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

_____

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

_____

_____

B. The amount of the claim.

_____

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

_____

_____

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

_____

_____

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

_____

_____

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them. N/A

11. State the names and address of all witnesses to the accident or occurrence. N/A

Name of Witness — Address

Name of Witness — Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

JOHN DASILVA — Name of Police Officer

UNION COUNTY — Police Department

Name of Police Officer — Police Department

B. Copy of Police Report attached:
(X) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

YES

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

NJM. INS. CO

301 SULLIVAN WAY. W. TRENTON, NJ 08628

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

YES

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
NEW JERSEY MANUFACTURES 301 SULLIVAN WAY, W. TRENTON, NJ 08628	F447276	PAID

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 3/3/2011

Maria Quintero

Claimant ~~or person filing claim on behalf of claimant~~

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: N/A

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: _____ **Signature:** _____

01/20/2011 at 02:05 PM
91561

Job Number: 5795

WESTFIELD COLLISION CENTER, INC
License #:03541A Federal ID #:223424057
404 SOUTH AVE EAST
Westfield, NJ 07090
(908)654-4212 Fax: (908)654-4246

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

Written By: Joseph Pardo
Adjuster:

Insured: MARIA AURIEMA
Owner: MARIA AURIEMA
Address: [redacted]
Cellular: [redacted]

Claim #2010-654867-1-F447276
Policy #
Deductible: $200.00
Date of Loss: 12/27/2010
Type of Loss: Comprehensive
Point of Impact: 12. Front

Inspect Location: WESTFIELD COLLISION CENTER, INC
404 SOUTH AVE EAST
Westfield, NJ 07090

Business: (908)654-4212

Insurance Company: -NJM

Days to Repair

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN
VIN: [redacted] **Lic:** UBN-53D NJ **Prod Date:** 10/2004 **Odometer:** 71868
Condition: Good

Air Conditioning	Rear Defogger	Tilt Wheel
Cruise Control	Telescopic Wheel	Intermittent Wipers
Keyless Entry	Alarm	Steering Wheel Controls
Message Center	Body Side Moldings	Wood Interior Trim
Dual Mirrors	Overhead Console	Traction Control
Stability Control	Fog Lamps	Signal Integrated Mirrors
Clear Coat Paint	Power Steering	Power Brakes
Power Windows	Power Locks	Power Driver Seat
Power Passenger Seat	Power Mirrors	Heated Mirrors
AM Radio	FM Radio	Stereo
Search/Seek	CD Player	Anti-Lock Brakes (4)
Driver Air Bag	Passenger Air Bag	Head/Curtain Air Bags
Front Side Impact Air Bag	Rear Side Impact Air Bags	4 Wheel Disc Brakes
Leather Seats	Bucket Seats	Heated Seats
Automatic Transmission	4 Wheel Drive	Overdrive
Aluminum/Alloy Wheels		

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
1		FRONT BUMPER				
2		O/H bumper assy			2.5	
3*	S01 Repl	Bumper cover Classic, Elegance w/o lmp wshr	1	428.00	Incl.	2.4
4		Add for Clear Coat				1.0

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE		LABOR	PAINT
5*	Rpr	LT Molding Classic w/o parktronic white				1.0	0.3
6		Add for Clear Coat					0.1
7	Refn	RT Molding Classic w/o parktronic white					0.3
8		Add for Clear Coat					0.1
9* S01	Repl	LT Bumper cover bracket	1	20.00		Incl.	
10* S01	Repl	LT Bumper cover guide	1	4.50		Incl.	
11 S01	R&I	License bracket sedan				0.2	
12 S01	Refn	RT Tow brkt cover white					0.2
13 S01		Add for Clear Coat					0.1
14 S01	R&I	Grille Avantgarde white				Incl.	
15		FRONT LAMPS					
16	Repl	LT Headlamp assy w/o xenon lamps	1	420.00		Incl.	
17		Aim headlamps				0.5	
18 S01	Repl	RT Headlamp assy w/o xenon lamps	1	420.00		0.3	
19 S01	R&I	RT Fog lamp assy w/o AMG package				Incl.	
20 S01	R&I	LT Fog lamp assy w/o AMG package				Incl.	
21 S01	R&I	RT Signal lamp				Incl.	
22 S01	R&I	LT Signal lamp				Incl.	
23 S01	Repl	LT Sealing ring	1	23.50			
24 S01	Repl	RT Sealing ring	1	23.50			
25 S01		COOLING					
26* S01	Repl	Radiator	1	270.00	m	Incl.	
27* S01	Repl	Radiator pin	2	7.80			
28* S01	Repl	Air baffle	1	27.50			
29 S01	R&I	Fan assy			m	Incl. M	
30* S01	Repl	Air baffle lower	1	37.00			
31 S01		INFORMATION LABELS					
32* S01	Repl	Warning label	1	4.00		0.2	
33 S01		AIR CONDITIONER & HEATER					
34* S01	Repl	Condenser	1	378.00	m	2.6 M	
35 S01		Evacuate & recharge			m	1.4 M	
36		RADIATOR SUPPORT					
37	Repl	LT Mount frame w/o C55 AMG	1	49.50	s	0.4	
38* S01	Repl	LT Mount frame support w/o C55 AMG	1	21.00			
39 S01	Repl	LT Strut	1	16.00	s	0.4	
40* S01	Repl	Upper tie bar w/o C55 AMG	1	51.00	s	0.5	0.0
41* S01	Repl	LT Support bracket w/o C55 AMG	1	15.50		0.2	
42* S01	R&I	Lower c'member w/C55 AMG			s	0.4	
43* S01	Repl	Cap	3	8.10			
44		HOOD & GRILLE					
45* S01	Repl	Hood w/o C55 AMG	1	720.00		2.2	3.0

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

	NO.	OP.		DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
	46			Add for Clear Coat				1.2
	47			Add for Underside(Complete)				1.5
	48			Add for Clear Coat				0.3
	49*	S01	Repl	Grille w/o Sport	1	244.00	Incl.	
	50*	S01	Repl	Safety catch	1	33.50	Incl.	
	51*	S01	Repl	Handle	1	4.20		
	52*	S01	R&I	Emblem			0.2	
	53*	S01	Repl	LT Lock upper	1	22.00	0.3	
	54*	S01	Repl	LT Lock lower	1	25.00	0.2	
	55*	S01	Repl	Hood bumper	1	6.50		
	56*	S01	Repl	Hood shim	1	5.50		
	57	S01	R&I	Insulation			Incl.	
	58*	S01	Repl	Striker	1	11.50	Incl.	
	59	S01	Repl	Insulation retainer	16	32.00		
	60	S01	R&I	R&I vent grille			Incl.	
	61	S01	Blnd	Vent grille white				0.6
	62#	S01	R&I	WASHER NOZZLE ON GRILLE			0.2	
	63*	S01	Repl	Handle spring	1	2.00		
	64#	S01	Repl	LOCK	1	3.50		
	65	S01	Repl	Release cable front	1	31.00	0.4	
	66#	S01	Repl	LT Lock lower cover rear	1	5.50		
	67*	S01	Repl	LT Lock lower cover front	1	5.50	0.2	
	68			FENDER				
N	69*	S01	Rpr	RT Fender w/o C55 AMG			3.5	2.0
	70			Overlap Major Adj. Panel				-0.4
	71			Add for Clear Coat				0.3
	72*	S01		Add for Edging				0.2
	73*	S01	Repl	LT Fender w/o C55 AMG	1	360.00	2.5	2.0
	74			Overlap Major Adj. Panel				-0.4
	75			Add for Clear Coat				0.3
	76			Add for Edging				0.5
	77			Add for Clear Coat				0.1
	78	S01	R&I	RT Fender liner front lower w/o C55 AMG			0.3	
	79	S01	R&I	LT Fender liner front lower w/o C55 AMG			Incl.	
	80	S01	R&I	RT Fender liner front upper w/o 4-Matic			Incl.	
	81	S01	R&I	LT Fender liner front upper w/o 4-Matic			Incl.	
	82	S01	R&I	LT Fender liner rear w/o C55 AMG w/o 4-Matic			Incl.	
	83	S01	R&I	RT Body side mldg Classic white			0.2	
	84	S01	R&I	LT Body side mldg Classic white			0.2	
	85*	S01	Repl	LT Front seal	1	9.25		
	86	S01		PILLARS, ROCKER & FLOOR				

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Job Number: 5795

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

NO.	OP.		DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
87	S01	R&I	LT Rocker molding w/o Sport			1.4	
88			FRONT DOOR				
89		R&I	LT Body side mldg w/o sport white			0.3	
90	S01	R&I	LT Weatherstrip front			0.2	
91	S01	R&I	LT Run channel			0.3	
92	S01	R&I	LT R&I trim panel			1.0	
93		R&I	LT Belt molding			0.3	
94		R&I	LT R&I mirror			0.5	
95		R&I	LT Handle, outside w/o sport white			0.3	
96		R&I	LT Window trim java			0.3	
97#		Repl	WASTE	1	4.00		
98#		Repl	COLOR TINT	1		0.5	
99#		Repl	RESET ELECTRONIICS	1		0.5	
100#	S01	Repl	COLOR SAND RUB	1		2.0	
101#		Repl	CLEAN UP & DETAIL	1	15.00		
102#		Repl	CAR COVER	1	5.00	0.2	
103#		Repl	COVER INTERIOR & JAMBS	1	5.00	0.2	
104#		Repl	CORROSION PROTECTION	1	10.00		
105#	S01	Repl	FLEX AGENT ADHESION PROMOTER	1	23.36		
106	S01		ELECTRICAL				
107	S01	R&I	Horn w/o proximity cruise 400HZ			0.2	
108	S01		ENGINE				
109	S01	R&I	RT Air inlet			0.3	
110	S01	R&I	LT Air inlet			0.3	
111*	S01	Repl	Motor cover	1	137.00	0.4	
112			OTHER CHARGES				
113#	S01		Towing	1	195.00		
			Subtotals ==>		4140.21	30.2	15.7

Line 69 : INCLUDES INNER EDGE OUTSIDE NOT ENOUGH TIME

Parts		3945.21
Body Labor	26.2 hrs @ $ 48.00/hr	1257.60
Paint Labor	15.7 hrs @ $ 48.00/hr	753.60
Mechanical Labor	4.0 hrs @ $ 50.00/hr	200.00
Paint Supplies	15.7 hrs @ $ 28.00/hr	439.60
Body Supplies	18.7 hrs @ $ 2.00/hr	37.40
Other Charges		195.00
SUBTOTAL		$ 6828.41
Sales Tax	$ 6633.41 @ 7.0000%	464.34
GRAND TOTAL		$ 7292.75

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Job Number: 5795

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

ADJUSTMENTS:	
Deductible	200.00
CUSTOMER PAY	$ 200.00
INSURANCE PAY	$ 7092.75

I authorize the above named shop in the repair of the vehicle described herein. I also authorize the use of this vehicle for the purpose of testing and transport. I understand that all charges aganist this vehicle must be satisfied before said vehicle can be released.

Signed_____Date_____

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide ERI5775, CCC Data Date 01/17/2011, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) or ALT OEM (Alternative OEM) parts are OEM parts that may be provided by or through alternate sources other than the OEM vehicle dealerships. OPT OEM or ALT OEM parts may reflect some specific, special, or unique pricing or discount. OPT OEM or ALT OEM parts may include "Blemished" parts provided by OEM's through OEM vehicle dealerships. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Recond. Recored parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2010 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

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PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

	NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
			------- CHANGED ITEMS -------				
	2	Repl	Bumper cover Classic, Elegance w/o lmp wshr	1	-412.00	Incl.	-2.4
	3* S01	Repl	Bumper cover Classic, Elegance w/o lmp wshr	1	428.00	Incl.	2.4
	8	Repl	LT Bumper cover bracket	1	-19.50	Incl.	
	9* S01	Repl	LT Bumper cover bracket	1	20.00	Incl.	
	16	Repl	Hood w/o C55 AMG	1	-685.00	-2.2	-3.0
	45* S01	Repl	Hood w/o C55 AMG	1	720.00	2.2	3.0
	20	Repl	Grille w/o Sport	1	-220.00	Incl.	
	49* S01	Repl	Grille w/o Sport	1	244.00	Incl.	
	21	Repl	Safety catch	1	-28.50	Incl.	
	50* S01	Repl	Safety catch	1	33.50	Incl.	
	22	Repl	Handle	1	-4.40		
	51* S01	Repl	Handle	1	4.20		
	24*	Rpr	RT Fender w/o C55 AMG			-1.0	-2.0
N	69* S01	Rpr	RT Fender w/o C55 AMG			3.5	2.0
	27	Repl	LT Fender w/o C55 AMG	1	-334.00	-2.5	-2.0
	73* S01	Repl	LT Fender w/o C55 AMG	1	360.00	2.5	2.0
	41#	Repl	COLOR SAND RUB	1		-1.6	
	100# S01	Repl	COLOR SAND RUB	1		2.0	
	46#	Repl	FLEX AGENT ADHESION PROMOTER	1	-10.00		
	105# S01	Repl	FLEX AGENT ADHESION PROMOTER	1	23.36		
			------- DELETED ITEMS -------				
	13	R&I	RT Headlamp assy w/o xenon lamps			-0.3	
			------- ADDED ITEMS -------				
	10* S01	Repl	LT Bumper cover guide	1	4.50	Incl.	
	11 S01	R&I	License bracket sedan			0.2	
	12 S01	Refn	RT Tow brkt cover white				0.2
	13 S01		Add for Clear Coat				0.1
	14 S01	R&I	Grille Avantgarde white			Incl.	
	18 S01	Repl	RT Headlamp assy w/o xenon lamps	1	420.00	0.3	
	19 S01	R&I	RT Fog lamp assy w/o AMG package			Incl.	
	20 S01	R&I	LT Fog lamp assy w/o AMG package			Incl.	
	21 S01	R&I	RT Signal lamp			Incl.	
	22 S01	R&I	LT Signal lamp			Incl.	
	23 S01	Repl	LT Sealing ring	1	23.50		
	24 S01	Repl	RT Sealing ring	1	23.50		
	25 S01		COOLING				
	26* S01	Repl	Radiator	1	270.00	m Incl.	
	27* S01	Repl	Radiator pin	2	7.80		
	28* S01	Repl	Air baffle	1	27.50		
	29 S01	R&I	Fan assy			m Incl. M	
	30* S01	Repl	Air baffle lower	1	37.00		

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
31	S01	INFORMATION LABELS				
32*	S01	Repl Warning label	1	4.00	0.2	
33	S01	AIR CONDITIONER & HEATER				
34*	S01	Repl Condenser	1	378.00	m 2.6 M	
35	S01	Evacuate & recharge			m 1.4 M	
38*	S01	Repl LT Mount frame support w/o C55 AMG	1	21.00		
39	S01	Repl LT Strut	1	16.00	s 0.4	
40*	S01	Repl Upper tie bar w/o C55 AMG	1	51.00	s 0.5	0.0
41*	S01	Repl LT Support bracket w/o C55 AMG	1	15.50	0.2	
42*	S01	R&I Lower c'member w/C55 AMG			s 0.4	
43*	S01	Repl Cap	3	8.10		
52*	S01	R&I Emblem			0.2	
53*	S01	Repl LT Lock upper	1	22.00	0.3	
54*	S01	Repl LT Lock lower	1	25.00	0.2	
55*	S01	Repl Hood bumper	1	6.50		
56*	S01	Repl Hood shim	1	5.50		
57	S01	R&I Insulation			Incl.	
58*	S01	Repl Striker	1	11.50	Incl.	
59	S01	Repl Insulation retainer	16	32.00		
60	S01	R&I R&I vent grille			Incl.	
61	S01	Blnd Vent grille white				0.6
62#	S01	R&I WASHER NOZZLE ON GRILLE			0.2	
63*	S01	Repl Handle spring	1	2.00		
64#	S01	Repl LOCK	1	3.50		
65	S01	Repl Release cable front	1	31.00	0.4	
66#	S01	Repl LT Lock lower cover rear	1	5.50		
67*	S01	Repl LT Lock lower cover front	1	5.50	0.2	
72*	S01	Add for Edging				0.2
78	S01	R&I RT Fender liner front lower w/o C55 AMG			0.3	
79	S01	R&I LT Fender liner front lower w/o C55 AMG			Incl.	
80	S01	R&I RT Fender liner front upper w/o 4-Matic			Incl.	
81	S01	R&I LT Fender liner front upper w/o 4-Matic			Incl.	
82	S01	R&I LT Fender liner rear w/o C55 AMG w/o 4-Matic			Incl.	
83	S01	R&I RT Body side mldg Classic white			0.2	
84	S01	R&I LT Body side mldg Classic white			0.2	
85*	S01	Repl LT Front seal	1	9.25		
86	S01	PILLARS, ROCKER & FLOOR				
87	S01	R&I LT Rocker molding w/o Sport			1.4	
90	S01	R&I LT Weatherstrip front			0.2	
91	S01	R&I LT Run channel			0.3	

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Job Number: 5795

PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

NO.	OP.	DESCRIPTION	QTY	EXT. PRICE	LABOR	PAINT
92	S01 R&I	LT R&I trim panel			1.0	
106	S01	ELECTRICAL				
107	S01 R&I	Horn w/o proximity cruise 400HZ			0.2	
108	S01	ENGINE				
109	S01 R&I	RT Air inlet			0.3	
110	S01 R&I	LT Air inlet			0.3	
111*	S01 Repl	Motor cover	1	137.00	0.4	
Other Charges:						
		------- ADDED ITEMS -------				
#	S01	Towing	1	195.00		
		Subtotals ==>		1918.31	15.1	1.1

Line 69 : INCLUDES INNER EDGE OUTSIDE NOT ENOUGH TIME

Parts		1723.31
Body Labor	11.1 hrs @ $ 48.00/hr	532.80
Paint Labor	1.1 hrs @ $ 48.00/hr	52.80
Mechanical Labor	4.0 hrs @ $ 50.00/hr	200.00
Body Supplies	8.6 hrs @ $ 2.00/hr	17.20
Paint Supplies	1.1 hrs @ $ 28.00/hr	30.80
Other Charges		195.00
SUBTOTAL		$ 2751.91
Sales Tax	$ 2556.91 @ 7.0000%	178.98
TOTAL SUPPLEMENT AMOUNT		$ 2930.89
NET COST OF SUPPLEMENT		$ 2930.89

Estimate	4361.86	JOE P JP
Supplement S01	2930.89	JOE P JP
Job Total	$ 7292.75	

CUSTOMER PAY $ 200.00
INSURANCE PAY $ 7092.75

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Signed_____Date_____

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PRELIMINARY SUPPLEMENT 1 WITH SUMMARY

2005 BENZ C240 AWD 6-2.6L-FI 4D SED WHITE Int:TAN

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UNION COUNTY POLICE DEPARTMENT

300 NORTH AVE. EAST
908-654-9800
WESTFIELD, NJ 07090

INVESTIGATION REPORT

Municipal Code: 2091
ORI: NJ0209100

DEPARTMENT CASE NUMBER	MUN. CODE	PHONE NUMBER	UCR	DEPARTMENT ARREST NUMBER	
I-2010-021609	2091	908-654-9800			

CRIME/INCIDENT	NJS	VICTIM NAME(Last Name, First Name, MI)	DOB
DAMAGE TO PROPERTY.	187-5.	AURIEMA, MARIA	11/16/1948

SSN NO.	AGE	SEX	RACE	ETHNICITY
[redacted]	62	F	W	N

DATE AND TIME	BETWEEN	HOUR	MONTH	DAY	YEAR	VICTIM'S HOME ADDRESS	PHONE
	☐	16:09	12	27	2010	[redacted]	[redacted]

CRIME/INCIDENT LOCATION	EMPLOYER	PHONE
PARKWAY DRIVE, CLARK NJ 07066		

MUNICIPALITY	COUNTY	CODE	PERSON REPORTING CRIME	DATE AND TIME
CLARK TOWNSHIP	UNION	2002	AURIEMA, MARIA	12/27/2010 16:09

TYPE OF PREMISES	WEAPONS - TOOLS	ADDRESS	PHONE
Street	N/A	[redacted]	[redacted]

MODUS OPERANDI

VEHICLE	YEAR	MAKE	MODEL	BODY TYPE	COLOR	REG. PLATE -STATE	VIN	VEHICLE VALUE
Damaged	2005	M B	C24	4DR	WT	UBN53D NJ	[redacted]	

VALUE STOLEN PROPERTY	CURRENCY	JEWELRY	FURS	CLOTHING	AUTO	MISC.

TOTAL VALUE STOLEN	TOTAL VALUE RECOVERED	TELETYPE ALARM	TECHNICAL SERVICES	TECHNICAL AGENCY
$0.00				

WEATHER	SIC	NIC	ASSISTING AGENCIES
SNOW			

NO. OF ACCUSED	ADULT	JUVENILE	STATUS CRIME	STATUS CASE	UCR STATUS	DATE CLEARED
				CLOSED		

NARRATIVE

On the above date and time I was dispatched to UC Parkway Drive for a fallen tree that caused damage to a citizen's car. Upon arrival I observed a tree blocking the roadway and it was apparent that the tree had struck a vehicle on the Winfield Park side of the roadway. The tree fell from the woods in Rahway River Park. The vehicle that was struck was a 2005 white 4 door Mercedes NJ tag UBN53D. Damage to the vehicle was to the hood, front bumper, headlights and unknown engine damage. I made contact with the owner Maria Auriema who came to scene. Ms. Auriema took pictures of the scene for her own records. Shade tree was notified and our unit maintained a traffic control point until the tree was removed. Pictures of the damaged car were taken by UCPD and attached to this report.

NAME	DATE OF REPORT	REVIEWED BY	SIGNATURE
CORPORAL DASILVA, JOHN 6067	12/27/2010	SERGEANT BLACK, GARY 6063	

enterprise DUPLICATE

2 E WESTFIELD AVE
ROSELLE PARK NJ 07204-2208

Bill To:

00000052 00026/00129 I 241A999999
MARIA AURIEMA
[redacted]

BILLING DETAIL

Description		Rate	Amount
24 DAYS	@	25.99	623.76
DSF			120.00
SALES TAX%		7.00	43.66

RENTAL INFORMATION

Date Out 12/28/10
Date In 1/20/11
Renter
MARIA AURIEMA

Additional Driver

Name
NO OTHER DRIVER PERMITTED

TOTAL CHARGES	787.42
LESS AMOUNT RECEIVED	307.42
CHARGED TO OTHERS	480.00
AMOUNT DUE ▶	.00

RENTAL VEHICLES CLAIM INFORMATION

Color WHITE
License No. ZUK19E
Claim #/Policy #/P.O. # 2010-654867
Model 10 CALI
Unit # 7D01DR
Insured AURIEMA* MARIA*
Date of Loss
Type of Loss INSURED
Type of Car MERCEDES-B
Repair Shop WESTFIELD CO

IMPORTANT INFORMATION

Billing Inquiries Call 908-298-0600
Fed Tax ID # 43-1487854

DUPLICATE COPY
PLEASE DISREGARD IF
ALREADY PAID

Please Return This Portion with Remittance

AMOUNT DUE ▶ .00

Remit to:

ENTERPRISE RENT-A-CAR
ATTN: ACCTS RECEIVABLE
PO BOX 840154
KANSAS CITY MO 64184-0154

Paid by:

MARIA AURIEMA
[redacted]

Customer#	Rental Agreement	Amount	GPBR
999999	D706882	.00	24EA

02/02

Enterprise

WNER OF VEHICLE:
RANCH ADDRESS:

DATE IN
DATE OUT

RENTAL TYPE | SOURCE # | I.D. #

RENTAL AGREEMENT NO.

RENTER

ART CHARGES IF DIFFERENT

ORIGINAL VEHICLE

COLOR	LICENSE NO.
MODEL	ECAR#
MILE-AGE IN	
MILE-AGE OUT	
DRIVEN	

CONDITION AND FUEL LEVEL AGREED TO X RENTER

NO DAMAGE

WINDSHIELD CONDITION: CLEAR STAR CRACKED

FRONT

X= DENT — = SCRATCH O= MISSING

CONDITION SAME ON RETURN Yes No

OUT E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F

IN E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F

BILL TO COMPANY

ATTN: PHONE EXT.

REFERENCE NUMBER:

ADDITIONAL AUTHORIZED DRIVER(S) - EXCEPT AS REQUIRED BY LAW, NONE PERMITTED WITHOUT OWNER'S WRITTEN APPROVAL.
I REQUEST OWNER'S PERMISSION TO ALLOW

WHO IS UNDER MY CONTROL AND DIRECTION TO DRIVE VEHICLE FOR ME AND ON MY BEHALF. I AM RESPONSIBLE FOR THEIR ACTS WHILE THEY ARE DRIVING, AND FOR FULFILLING TERMS AND CONDITIONS OF THIS **RENTAL AGREEMENT (AGREEMENT)**. USE OF VEHICLE BY AN UNAUTHORIZED DRIVER **WILL AFFECT** MY LIABILITY AND RIGHTS UNDER THIS AGREEMENT.

RENTER: X

PERMISSION GRANTED TO OPERATE VEHICLE ONLY IN THE STATE OF RENTAL AND THE FOLLOWING **STATE(S)**:

NJ NY CT- NO SMOKING

OPERATION IN ANY OTHER STATE OR COUNTRY WILL AFFECT YOUR LIABILITY AND RIGHTS UNDER THIS **AGREEMENT**.

PTIONAL PRODUCTS NOTICE:
E OFFER FOR AN ADDITIONAL ARGE THE FOLLOWING OPTIONAL ODUCTS: DAMAGE WAIVER; RSONAL ACCIDENT INSURANCE;)ADSIDE ASSISTANCE PROTEC-)N AND SUPPLEMENTAL LIABILITY OTECTION. BEFORE DECIDING HETHER TO PURCHASE ANY OF ESE PRODUCTS, YOU MAY WISH DETERMINE WHETHER YOUR RSONAL INSURANCE OR CREDIT RD PROVIDES YOU COVERAGE RING THE RENTAL PERIOD. THE RCHASE OF ANY OF THESE ODUCTS IS NOT REQUIRED TO NT VEHICLE

RENTER **DECLINES OPTIONAL DAMAGE WAIVER (DW)** AND **ASSUMES DAMAGE RESPONSIBILITY.** SEE PAGE 3, PARAGRAPH 6. RENTER: X	RENTER **ACCEPTS OPTIONAL DAMAGE WAIVER (DW)** AT FEE SHOWN IN COLUMN TO RIGHT. SEE OPTIONAL PRODUCTS NOTICE TO LEFT AND PAGE 3, PARAGRAPH 16. DW IS NOT INSURANCE. RENTER: X
RENTER **DECLINES OPTIONAL PERSONAL ACCIDENT INSURANCE (PAI).** SEE PAGE 3, PARAGRAPH 9. RENTER: X	RENTER **ACCEPTS OPTIONAL PERSONAL ACCIDENT INSURANCE (PAI)** AT FEE SHOWN IN COLUMN TO RIGHT. SEE OPTIONAL PRODUCTS NOTICE TO LEFT AND PAGE 3, PARAGRAPH 18. RENTER: X
RENTER **DECLINES OPTIONAL SUPPLEMENTAL LIABILITY PROTECTION (SLP).** SEE PAGE 3, PARAGRAPH 7. RENTER: X	RENTER **ACCEPTS OPTIONAL SUPPLE-MENTAL LIABILITY PROTECTION (SLP)** AT FEE SHOWN IN COLUMN TO RIGHT. SEE OPTIONAL PRODUCTS NOTICE TO LEFT AND PAGE 3, PARAGRAPH 17. RENTER: X

ACKNOWLEDGMENT OF THE ENTIRE AGREEMENT, PAGES 1 THROUGH 4.
I HAVE READ AND AGREE TO THE TERMS AND CONDITIONS ON PAGES 1 THROUGH 4 OF THIS AGREEMENT AND BY MY SIGNATURE BELOW I AM THE RENTER UNDER THIS AGREEMENT. BY SIGNING BELOW, I AM AUTHORIZING OWNER TO PROCESS CHARGES ON MY CREDIT CARD(S) AND OR DEBIT CARD(S) FOR ADVANCE DEPOSITS, INCREMENTAL AUTHORIZATIONS DEPOSITS, AND CHARGES INCURRED AS WELL AS PAYMENTS REFUSED BY A THIRD PARTY TO WHOM BILLING WAS DIRECTED. **I CERTIFY THAT THE DRIVERS LICENSE(S) PRESENTED IS CURRENTLY VALID AND IS NOT SUSPENDED, EXPIRED, REVOKED, CANCELLED OR SURRENDERED**

RENTER: X DATE

OWNER REP X EMPL. #

REPLACEMENT VEHICLE

DATE OUT

COLOR	LICENSE NO.
MODEL	ECAR#
MILE-AGE IN	
MILE-AGE OUT	
DRIVEN	

CONDITION AND FUEL LEVEL AGREED TO X RENTER

NO DAMAGE

WINDSHIELD CONDITION: CLEAR STAR CRACKED

FRONT

X= DENT — = SCRATCH O= MISSING

CONDITION SAME ON RETURN Yes No

UT E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F

E 1/8 1/4 3/8 1/2 5/8 3/4 7/8 F

I WILL RETURN CAR BY: DATE	TIME	DEPOSIT(S): AMOUNT	PAID BY

ADDITIONAL INFORMATION

TOTAL CHARGES	
DEPOSITS	
REFUNDS	
AMOUNT DUE	

CLOSED BY

PAID BY	CASH	CHECK	CHARGE
RECEIPT OF CASH REFUND	DATE	AMOUNT	RECEIVED BY

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED

UNION COUNTY COUNSEL
RECEIVED
FEB 25 2011
ADMINISTRATION BUILDING
ELIZABETH, NJ

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Bell James Lawrence — 7/23/87
Last Name, First, Middle — Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name BARRY E. ROSENBERG, ESQ.

Mailing Address P.O. BOX 350

BOUND BROOK NJ 08805 732 356-9400 FAX 732-805-0070
City, State Zip Code

Relationship to claimant: Attorney at Law X or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date Nov. 28, 2010 Time 4:30pm

B. Describe the location or place of the accident or occurrence

Westfield — Westfield Train Station (North Side)
Municipality — Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

I was sitting in a chair on the stage setup by the Union County Board of Chosen Freeholders and the speaker behind me fell on my head and my trumpet because the legs on the support stand were not out all the way.

4. A. Claim for Damages (Check the appropriate block)

(✓) Personal Injury (✓) Property Damage
( ) Other - Explain in detail_____

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:
Deep head cut which resulted in 3 stitches.

B2. Do you claim permanent disability resulting from this injury?

( ) Yes (X) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility
1) Care Station Medical Group
2) Trinitas Hospital (Dr. Millman)

b. Address
1) 328 W St. Georges Ave, Linden, NJ 07036
2) 240 Williamson St., Elizabeth, NJ 07202

c. Dates of treatment or services
1) 11/28, 11/30, 12/5
2) 12/7, 12/18 (MRI)

d. Amount of charges to date
1) $45 (co-pays)

e. Amount paid or payable by other sources such as insurance

See schedule "A", Annexed.

B4. If you claim loss of wages or income as a result of the injury, state

City Music Center
Name of Employer

Address of Employer 200 Market St. Kenilworth, NJ 07033

Instrument Cleaner/Repairman
Your Occupation

Date of Employment August 2006

$10.50/hr
Rate of Pay

Dates of absence from work 11/29/2010, 11/30/2010 (4 hours), 12/1/2010

Date returned to work First full day 12/2/2010

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

N/A

6. If you claim property damage:

A. Describe the property damage:

Dents in my trumpet and broken braces on the trumpet.

B. The present location and time when the property may be inspected:.

[redacted]
LOCATION

Any day
DATE

Any time
TIME (Call to make sure I am home or leave work to meet at my house

C. Date property was acquired.

Sept 2001

D. Cost of property.

$1400

E. Value of property at time of accident.

$1000

F. Description of damage.

Dent in the bell flair and broken brace on the bell flair

G. Has the damage been repaired? yes

If yes, by whom, when and cost of repair.

[redacted] Ken Reed — 11/30/10 — $160.50

Repaired by (KWR Musical Services) | When | Costs of Repairs

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

REPAIR TO TRUMPET

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

NONE AT THIS TIME

B. The amount of the claim.

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union County Board of Chosen Freeholders - PARKS AND RECREATION
10 Elizabethtown[redacted] Plaza, Elizabeth, NJ 07207

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

The guy who set up the stage and PA speakers.
AT WESTFIELD TRAIN STATION - 11/28/10.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

The support legs on the speaker stand were barely put out, making it highly unstable and easy to topple.

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

NONE AT THIS TIME.

11. State the names and address of all witnesses to the accident or occurrence.

Michael L. Conway — Name of Witness

[redacted] — Address

Name of Witness — Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Dennis DaSilva — Name of Police Officer

Westfield Police — Police Department

Name of Police Officer — Police Department

B. Copy of Police Report attached:
(X) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

NOT AT THIS TIME.

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

SEE SCHEDULE "A" ANNEXED.

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Aetna	W1161 13393 Choice POS II	See Schedule "A"
Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

√ A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

√ C. Copies of all written reports of all expert witnesses and treating physicians.

√ D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

E. Completed "Authorization for Release of Health Information", see attached form.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: FEB. 24, 2011

Jan L Bell

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: James L. Bell

Soc. Sec. Number: [redacted] **Date of Birth:** 7/23/87

Patient Address: [redacted]

City / State / Zip Code: [redacted]

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: Care Station Medical Group

Address: 328 W St. Georges Ave.

City / State / Zip Code: Linden, NJ 07036

Name of Provider or Facility: Trinitas Hospital (Dr. Millman)

Address: 240 Williamson St.

City / State / Zip Code: Elizabeth, NJ 07202

Name of Provider or Facility:

Address:

City / State / Zip Code:

The health information to be released (include specific description of injury and dates of treatment): Laceration on the head (including stitches) & MRI Results.

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: James L Bell
(Person making claim)

Date: Feb. 21, 2011 **Signature:** James L Bell

Claimant - James L. Bell
Date of Loss – November 28, 2010
Schedule "A" – Medical Charges and Benefits Paid (Aetna)

Date of Treatment

November 28, 2010
$313.00 Charged
$201.95 Allowed
$175.95 Paid

November 30, 2010
$67.00 Charged

December 5, 2010
$131.00 Submitted
$131.00 Allowed

December 7, 2010
$175.00 Charged
$173.10 Allowed
$53.10 Paid

December 18, 2010
$2,192.00 Charged
$1,612.65 Allowed
$1,612.65 Paid

Estimate

KWR Musical Services
17 Jacksonburg Rd
Blairstown, NJ 07825
908-358-5788

Name/Address

Jim Bell
[redacted]

Date	Estimate No.
11/30/10	119

Description	Quantity	Price	Total
Besson Trumpet Repair Replace broken brace, remove dents & service horn	1	150.00	150.00T
NJ Sales Tax		7.00%	10.50

After silence, that which comes nearest to expressing the inexpressible is music.

Total $160.50

Westfield Police Department

425 East Broad St
Westfield, NJ 07090
Phone: (908) 789-4000 Fax: (908) 789-4007

Incident Report

Incident# :10-026809

INCIDENT DETAILS

Incident# 10-026809	**Dispatched Date** 11/28/2010 16:26:04	**Caller Name**
Reported Date 11/28/2010 16:25:53	**Arrived Date** 11/28/2010 16:26:08	**Finished Date** 11/28/2010 16:55:00
Occurred From 11/28/2010 16:25:53	**Occurred To** 11/28/2010 16:25:53	**CAD CFS** 7029 MEDICAL-INJURIES/BLEEDING
RMS CFS 7029 - MEDICAL-INJURIES/BLEEDING	**Crime Location** NORTH SIDE TRAIN STATION PARKING LOT Westfield,NJ 07090	**Premise Type**
Call Taker 3088-Margeotes, Paul	**Dispatcher**	**Primary Officer** 170-DaSilva, Dennis

CRIME DETAILS

CFS Description 7029 MEDICAL-INJURIES/BLEEDING	**Location Type**	**Att-Comp** Completed

NAME DETAILS

Name BELL, JAMES L	**DOB** 07/23/1987	**Age** 23
Height	**Weight**	**SSN** [redacted]
Sex Male	**Race** White	**Ethinicity** Not of Hispanic Origin
Address [redacted]	**Eye Color**	**Hair Color**
Phone#	**Resident** Nonresident	**Jacket#**
Local#	**SBI#**	**DL#** [redacted]

NARRATIVE DETAILS

Narrarive Type	Narrative Date	Reported By	
NS - Supplementary Narrative	11/28/2010	170-DaSilva, Dennis	

narrative

ON 11-28-10 AT APPROX. 16:25 HOURS, I, PATROLMAN D. DASILVA, WAS DISPATCHED TO THE NORTH SIDE FIRE HOUSE, LOCATED AT 405 WEST NORTH AVENUE, WESTFIELD, NJ 07090, ON THE REPORT OF AN INDIVIDUAL WHO SUFFERED A LACERATION TO HIS HEAD, AND WAS SEEKING EMERGENCY MEDICAL CARE AT THAT LOCATION.UPON ARRIVAL AT THE FIRE HOUSE, I SPOKE WITH JAMES L.

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

UNION COUNTY COUNSEL
RECEIVED
MAR 15 2011
ADMINISTRATION BUILDING
ELIZABETH, NJ

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Batten Ethel G.
Last Name, First, Middle

11/4/46
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A. Date 2/6/11 Time 6:40 PM

B. Describe the location or place of the accident or occurrence

Union
Municipality

400 Block Vauxhall Road North of Hendricks In Front of Firehouse
Exact location of the occurrence

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

TRAVELING NORTH HIT 2 VERY LARGE POT Holes IMMEDIATE FLAT PASSENGER FRONT - Hugh BUBBLE IN PASSENGER REAR.

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury ( ) Property Damage

(X) Other - Explain in detail REPLACEMENT OF TWO TIRES

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer Address of Employer

Your Occupation Date of Employment

Rate of Pay Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage:
Loss of Two Tires

B. The present location and time when the property may be inspected:.

LOCATION DATE TIME

C. Date property was acquired.
9-8-05

D. Cost of property.
$203.09 x 2 = $406.18 + TAX $27.5

E. Value of property at time of accident.
$203.09 x 2 = $406.18 + TAX $27.5

F. Description of damage.

TIRES BLOWN OUT FROM POT HOLE

G. Has the damage been repaired?

If yes, by whom, when and cost of repair.

RAY CATENA (Repaired by) 2/7/11 (When) $433.68 (Costs of Repairs)

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage.

COST OF 2 TIRES $433.68

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

B. The amount of the claim.

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

COUNTY OF UNION

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

POT HOLES NOT REPAIRED

10. State the name and address of any other persons against whom you are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

_____

_____

_____

11. State the names and address of all witnesses to the accident or occurrence.

_____ _____

Name of Witness Address

_____ _____

Name of Witness Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

_____ _____

Name of Police Officer Police Department

_____ _____

Name of Police Officer Police Department

B. Copy of Police Report attached:

( ) Yes (X) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice. NO

_____

_____

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

_____

_____

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

NO (SEE ATTACHED)

_____

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
USAA	689594	0

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

B. Full copies of all appraisals and estimates of property damage claims by you.

C. Copies of all written reports of all expert witnesses and treating physicians.

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: 3/8/11

Ethel Batten

Claimant or person filing claim on behalf of claimant.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The

County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: _____ **Signature:** _____

Mercedes-Benz

Ray Catena of Union LLC

95 Progress Street
UNION, NJ 07083
(908) 379-7201
www.raycatena.com

CELL: [redacted]

110700 JAMES ROGERS 0480 486 02/07/11 M1CS649251

ETHEL BATTEN [redacted] 114.00 YAL8355 30,212 BLK/CHAR LT

06/MERCEDES-BENZ/E350W4/4 DOOR 06/10/06

[redacted] 51114 04/20/06

ETHEL_707@VERIZON.NET VIN 02/07/11

[redacted] C# 2110871X208171 E# 27297230364832 MO: 30212

LABOR & PARTS----------

J# 1 98MBZRENT RENTAL INTERNAL TECH(S):0199 0.00
WAITER

PARTS	QTY	FP-NUMBER	DESCRIPTION	UNIT PRICE	
			JOB # 1 TOTAL PARTS		0.00
			JOB # 1 TOTAL LABOR & PARTS		0.00

J# 2 40MBZ-TIRE-2-D REPLACE 2 TIRE TECH(S):0199 INTERNAL
CLIENT STATES THE RT FRONT TIRE IS FLAT & THE RT REAR
HAS A BUBBLE. ROTATE THE REAR TO THE FRONT.
PT#Q8400764
R/ DOT LMPR NXH6 2510 R/F 3510
REPLACED BOTH RIGHT SIDE TIRES & ROTATED THE RIGHT REAR
TO THE LEFT FRONT.

PARTS	QTY	FP-NUMBER	DESCRIPTION	UNIT PRICE	
JOB # 2	2	Q8400764	24545R17PROCONT	203.09	406.18
JOB # 2	2	220-401-12-94	BALANCING WE	13.75	27.50
			JOB # 2 TOTAL PARTS		433.68
			JOB # 2 TOTAL LABOR & PARTS		433.68

MISC	CODE	DESCRIPTION	CONTROL NO	
JOB # 2	TIRETAX1	NJ TIRE TAX		3.00
			TOTAL - MISC	3.00

ESTIMATE----------
CLIENT HEREBY ACKNOWLEDGES RECEIVING
ORIGINAL ESTIMATE OF $479.01 (+TAX)
TOTALS----------

****
* METHOD OF PAYMENT
* [ ] CASH [ ] CHECK *
* [ ] A/X [ ] VISA
* [ ] MASTER
* [ ] RCMC CHARGE
****

THANK YOU
****

TOTAL LABOR....	0.00
TOTAL PARTS....	433.68
TOTAL SUBLET...	0.00
TOTAL G.O.G....	0.00
TOTAL MISC CHG.	3.00
TOTAL MISC DISC	0.00
TOTAL TAX.....	30.36
TOTAL INVOICE $	**467.04**

CLIENT SIGNATURE

********** DUPLICATE INVOICE **********

SF639921 Q (03/07)

USAA®
9800 Fredericksburg Road
San Antonio, Texas 78288

Notice of loss receipt: February 25, 2011

04664.73GH.JSS164875465.01.01.273

ETHEL G BATTEN
[redacted]

February 25, 2011

Reference: Claim doesn't exceed deductible

Dear Mrs. Batten,

We received your collision with pothole claim, referenced below. This type of loss is covered under your Automobile policy. However, the loss doesn't exceed your $500 deductible. Your policy only pays if a loss exceeds your deductible.

Claim #:	689594
Date of loss:	February 6, 2011
Loss Location:	Union, New Jersey

If you believe this claim has been wrongfully declined or rejected, in whole or in part, or that there is a dispute as to liability or damages, you have the right to have the matter reviewed by the New Jersey Department of Insurance.

Office of Insurance Claims Ombudsman
Department of Banking and Insurance
P.O. Box 472
Trenton, NJ 08625-0472
Telephone: 1-800-446-7467
Telefax: 1-609-292-2431
E-mail: ombudsman@dobi.state.nj.us

You may submit correspondence to:

Address:	P.O. Box 33490 San Antonio, Texas 78265
Fax:	800-292-8829
Phone:	**1-800-531-8722, Ext. 7486**

Sincerely,

Leslie Newbury

Leslie N Newbury
Northeast Region
United Services Automobile Association

CLAIM FOR DAMAGES AGAINST UNION COUNTY

IF CLAIM IS BEING MADE FOR SPOUSE OR CHILDREN,
SEPARATE TORT CLAIM FORMS MUST BE SUBMITTED.

Forward To: Union County Counsel
Administration Building
Elizabeth, New Jersey 07207

1. Claimant:

Caputo Michelle C
Last Name, First, Middle

2/14/66
Date of Birth

[redacted]
Street Address/Mailing Address

[redacted]
City, State Zip Code

[redacted]
Social Security No.

2. If notices and correspondence in connection with this claim are to be sent to a person other than claimant, please state:

Name

Mailing Address

City, State Zip Code

Relationship to claimant: Attorney at Law ( ) or

Explain Relationship

3. The occurrence or accident which gave rise to this claim:

A.

Date Sunday 1/23/11 Time 10:00 am

B. Describe the location or place of the accident or occurrence

~~Springfield~~
Municipality

~~southbound on So. Springfield~~ Avenue
Exact location of the occurrence
approaching Rt. 22 overpass

C. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

While driving in travel lane, hit

pothole causing tire to immediately go flat

4. A. Claim for Damages (Check the appropriate block)

( ) Personal Injury (X) Property Damage
( ) Other - Explain in detail

B. If you claim Personal Injury;

B1. Describe your injuries resulting from this accident or occurrence:

B2. Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

B3. For each hospital, doctor or other practitioner rendering treatment, examination, or diagnostic service, state:

a. Name of Hospital, Doctor or other Facility

b. Address

c. Dates of treatment or services

d. Amount of charges to date

e. Amount paid or payable by other sources such as insurance

B4. If you claim loss of wages or income as a result of the injury, state

Name of Employer | Address of Employer

Your Occupation | Date of Employment

Rate of Pay | Dates of absence from work

Date returned to work

NOTE: If your claim for loss of income arises from self-employment or other than taxes, attach a calculation showing the basis of your calculation of loss.

5. Set forth any and all other losses or damages claimed by you.

6. If you claim property damage:

A. Describe the property damage: flat tire/bent rim

B. The present location and time when the property may be inspected:.

in my garage [redacted] at your convenience

LOCATION DATE TIME

C. Date property was acquired. car was purchased in 2003

D. Cost of property. included with car

E. Value of property at time of accident.

$250 (based on cost to replace rim)

F. Description of damage.

tire went flat due to bent rim

G. Has the damage been repaired? Replaced, not repairable per the company below.

If yes, by whom, when and cost of repair.

Apollo Battery & Tire	2/3/11	$250.00
Repaired by	When	Costs of ~~Repairs~~ Replacement

H. Attach each estimate of repair costs to this form.

I. Set forth in detail the loss claimed by you for property damage. $250.00

$200 for replacement rim, plus $50 "core" charge because original rim was not repairable

7. A. Set forth in detail all other items of loss or damages claimed by you and the method by which you made the calculation.

B. The amount of the claim.

$250.00

8. A. State the name and address of the County agency or agencies that you claim caused your damage.

Union County Road Dept. (?)

B. State the names of County employees whom you claim were at fault, including any information that will assist in identifying and locating them.

unknown at this time

9. State the negligence or wrongful acts of the County agency and County employees which caused your damages.

failure to maintain road in safe driving condition

10. State the name and address of any other persons against whom **you** are making a claim arising out of this accident and your theory of negligence or wrongful acts by them.

11. State the names and address of all witnesses to the accident or occurrence.

unknown passers-by
Name of Witness

Address

Name of Witness

Address

12. A. State the names of all police officers and police departments who investigated the accident and attach a copy of the police report, if any.

Jamal Minitee
Name of Police Officer

Union County
Police Department

Kevin A. Joy
Name of Police Officer

Union County
Police Department

B. Copy of Police Report attached:
(x) Yes ( ) No

13. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice.

no

If yes, set forth the names and addresses of all persons and insurance companies against whom you have made such claims.

14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

No, copy of auto policy delcaration page

enclosed, showing $500.00 collision deductible

For each such policy, state the name and address of the insurance company, policy number and benefits paid or payable.

Name & Address of Ins. Co.	Policy Number	Benefits Paid or Payable
Heights Insurance Agency (Allstate) 302 Springfield Ave., Berkeley Heights, NJ 07922	8 09 182364	none ($500 deductible)

15. Have you received or agreed to receive any money from anyone for the damages claimed herein.

( ) Yes (X) No

If so, set forth the details of such agreement.

16. The following items must be submitted with this notice:

A. Copies of itemized bills for each medical expense and other losses and expenses claimed.

n/a

B. Full copies of all appraisals and estimates of property damage claims by you.

1 page - Apollo Battery & Tire

C. Copies of all written reports of all expert witnesses and treating physicians.

1 page - Union County PD Investigation Report Case #Y-2011-001317

D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income.

n/a

E. Completed "Authorization for Release of Health Information", see attached form.

n/a

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statements made herein are willfully false or fraudulent, that I am subject to punishment provided by law.

DATED: February 24, 2011

Michelle Capito

Claimant or person filing claim on behalf of claimant.

N/A

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____

Soc. Sec. Number: _____ **Date of Birth:** _____

Patient Address: _____

City / State / Zip Code: _____

My health information is to be released by the following physicians, hospitals, healthcare facilities and/or healthcare providers:

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

Name of Provider or Facility: _____

Address: _____

City / State / Zip Code: _____

The health information to be released (include specific description of injury and dates of treatment):

_____

_____

_____

My health information is to be released to:

The County of Union
Office of County Counsel
10 Elizabethtown Plaza
Elizabeth, New Jersey 07207

The purpose of this disclosure is to allow the County of Union to evaluate the medical condition of the individual listed above in connection with their Tort Claim against the County. This information will be utilized by the County of Union to determine the validity and severity of any claimed medical condition for the purpose of potential settlement. The County reserves the right to have the disclosed health information evaluated by an outside physician or healthcare provider, as appropriate.

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. I understand that authorizing disclosure of this health information is voluntary and that I can refuse to sign this authorization. I further understand that I may obtain a copy of the information to be used or disclosed. The County of Union may not condition treatment, payment, enrollment or eligibility for health benefits on whether or not this Release is executed. I understand that I may revoke this authorization at any time by notifying the County of Union, Office of County Counsel in writing; however, this revocation will not have any effect on actions taken prior to any revocation. If this authorization is not revoked, it will terminate one year from the date of my signature. This Release is intended to comply with the Privacy Regulations enacted under the *Health Insurance Portability and Accountability Act* (HIPAA). (45 C.F.R. 164.508).

Printed Name of Patient Authorizing this Release: _____
(Person making claim)

Date: _____ **Signature:** _____

Allstate New Jersey Insurance Company

Policy Number : 8 09 182364 08/18 **Your Agent: Heights Ins. Agency (908) 464-4500**
Policy Effective Date: Feb. 18, 2011

COVERAGE FOR VEHICLE # 1

2003 Jaguar X-Type

COVERAGE	LIMITS		DEDUCTIBLE	PREMIUM
Automobile Liability Insurance				
• Bodily Injury	$100,000	each person	Not Applicable	$167.00
	$300,000	each accident		
• Property Damage	$50,000	each accident		
Basic Personal Injury Protection (Please see the attached Supplement to Policy Declarations for complete coverage, limits and deductibles.)				$87.00
Uninsured Motorists Insurance				$31.00
• Bodily Injury	$100,000	each person	Not Applicable	
	$300,000	each accident		
• Property Damage	$50,000	each accident	$500	
(Please see the attached Supplement to Policy Declarations for complete coverage and limits.)				
Auto Collision Insurance (Safe Driving Deductible Reward - deductible reduction amount available is $500)	Actual Cash Value		$500	$236.00
Auto Comprehensive Insurance	Actual Cash Value		$500	$85.00
Rental Reimbursement Coverage	up to $30 per day to a maximum of $900		Not Applicable	$21.60
Total Premium for 03 Jaguar X-Type				**$627.60**

DISCOUNTS

Your premium for this vehicle reflects the following discounts:

Multi-Car	$92.00	Anti-theft	$13.00
Preferred Plus	$1,308.00	Passive Restraint	$31.00
Multi-Policy	$54.00		

Additional Factor(s) Applied

Your premium reflects an additional factor(s) which results in the following additional premium:

Vehicle	$66.00	Supplemental Tier Factor	$28.00

RATING INFORMATION

This vehicle is driven over 7,500 miles per year, 0-3 miles to work/school, with no unmarried driver under 25

TIER INFORMATION

Tier: 1 Discount: **Preferred Plus** Level: 1 See Tier Rating Supplement for details.