



# APOLLO BATTERY & TIRE

44 Righter Avenue/Route 46 West  
 Denville, NJ 07834  
 (973) 625-0213

**VALUE AND INTEGRITY**  
*for your family's safety, Since 1969.*

|                                     |  |  |         |                     |
|-------------------------------------|--|--|---------|---------------------|
| NAME/ADDRESS<br>THANK YOU VERY MUCH |  | ACCOUNT NO.                              | H-PHONE | REFERENCE NO. 681   |
|                                     |  | PO #                                     | W-PHONE | DATE TIME 3/11 7:42 |
|                                     |  | RESALE NO.                               | VIN NO. | WORKS NO. 32321     |
| YEAR/MAKE/MODEL                     |  | LICENSE NO.                              | TAG NO. | NEXT INSP. DATE     |
| SAVE PARTS<br>Y N                   |  | ALL PARTS NEW UNLESS OTHERWISE SPECIFIED |         | PROMISED DATE/TIME  |
|                                     |  |  |         | MILEAGE             |
|                                     |  |  |         | WRITTEN BY 1S       |

| ESTIMATE  | AMOUNT | DATE | TIME | EMPLOYEE | PHONE | CUSTOMER |
|-----------|--------|------|------|----------|-------|----------|
| ORIGINAL  |        |      |      |          |       |          |
| REVISED 1 |        |      |      |          |       |          |
| REVISED 2 |        |      |      |          |       |          |

I acknowledge notice and oral approval of an increase in the original estimate price.  
 X

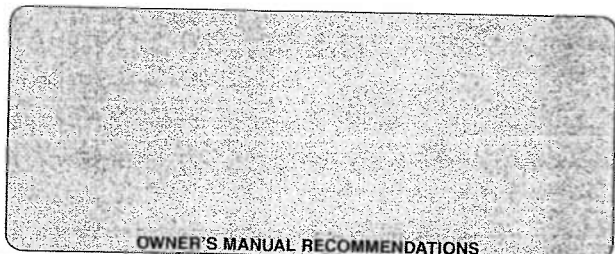
DISCLAIMER OF WARRANTIES: ANY WARRANTIES ON THE PRODUCTS SOLD ARE THOSE MADE BY THE MANUFACTURER. THE SELLER HEREBY EXPRESSLY DISCLAIMS ALL WARRANTIES, EITHER EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE AND NEITHER ASSUMES NOR AUTHORIZES ANY OTHER PERSON TO ASSUME FOR IT ANY LIABILITY IN CONNECTION WITH THE SALE OF SAID PRODUCTS. BUYER SHALL NOT BE ENTITLED TO RECOVER FROM THE SELLER ANY CONSEQUENTIAL DAMAGES, DAMAGES TO PROPERTY, DAMAGE FOR LOSS OF USE, LOSS OF TIME, LOSS OF PROFIT OR INCOME OR ANY OTHER INCIDENTAL DAMAGES.

EMISSION WAIVER - I understand that I have the right to have emission service and/or adjustment done elsewhere. I hereby waive this right at this time.  
 X

| PARTS & OTHERS **Original** |          |              |        |           |
|-----------------------------|----------|--------------|--------|-----------|
| QTY.                        | PART NO. | DESCRIPTION  | EACH   | EXTENSION |
| 1                           |          | WHEEL #59761 | 200.00 | 200.00    |
| 1                           |          | CORE         | 50.00  | 50.00     |

| MISC. |             |           |
|-------|-------------|-----------|
| QTY.  | DESCRIPTION | EXTENSION |
|       |             |           |

I hereby accept the initial estimate and agree to the terms and conditions herein set forth and hereby authorize the service and repair and/or installation work to be done along with the necessary materials and hereby grant you and/or your employees and/or designees permission to operate the vehicle herein described on streets, highways elsewhere for the purpose of testing or inspection. I hereby authorize the rate of the vehicle at the rate of \_\_\_\_\_ per day beginning the \_\_\_\_\_ day after repairs are completed. An express mechanic's is hereby acknowledged on vehicle to secure the amount of towing, storage and/or repairs. You will not be held responsible for loss or damage to vehicle or accessories or articles left in vehicle in case of theft, vandalism, accident, or any other cause beyond your control. In the event legal action is necessary to enforce this contract, I will pay reasonable attorney's fees and court cost.



| TOTALS   |        |
|----------|--------|
| PARTS    | 250.00 |
| MISC.    |        |
| OTHER    |        |
| SUBLET   |        |
| SUBTOTAL | 250.00 |
| TAX      | 17.50  |
| TOTAL    | 267.50 |

|  |             |              |           |             |           |                    |            |            |
|--|-------------|--------------|-----------|-------------|-----------|--------------------|------------|------------|
| AUTHORIZED BY: <input checked="" type="checkbox"/> X | CASH AMOUNT | CHECK AMOUNT | CHECK NO. | C.C. AMOUNT | C.C. TYPE | C.C. APPROVAL CODE | ON ACCOUNT | THANK YOU! |
|--|-------------|--------------|-----------|-------------|-----------|--------------------|------------|------------|

# UNION COUNTY POLICE DEPARTMENT

300 NORTH AVE. EAST

908-654-9800

WESTFIELD, NJ 07090

# INVESTIGATION REPORT

Municipal Code: 2091

ORI: NJ0209100

|   |                   |                              |     |                          |
|---|-------------------|------------------------------|-----|--------------------------|
| DEPARTMENT CASE NUMBER<br>I-2011-001317 | MUN. CODE<br>2091 | PHONE NUMBER<br>908-654-9800 | UCR | DEPARTMENT ARREST NUMBER |
|---|-------------------|------------------------------|-----|--------------------------|

|  |                     |   |           |          |                   |
|--|---------------------|---|-----------|----------|-------------------|
| CRIME/INCIDENT<br>DISABLED MOTOR VEHICLE<br>PROPERTY DAMAGE, NON | NJS<br>DVER<br>PDAM | VICTIM NAME (Last Name, First Name, MI)<br>CAPUTO, MICHELLE C |           |          | DOB<br>02/14/1966 |
|  |                     | SSN NO. <i>★</i><br>[REDACTED]                                | AGE<br>44 | SEX<br>F | RACE              |

|      |                          |       |       |     |      |                      |       |
|------|--------------------------|-------|-------|-----|------|----------------------|-------|
| DATE | BETWEEN                  | HOUR  | MONTH | DAY | YEAR | VICTIMS HOME ADDRESS | PHONE |
| AND  | <input type="checkbox"/> | 10:23 | 01    | 23  | 2011 | [REDACTED]           |       |
| TIME |                          |       |       |     |      | [REDACTED]           |       |

|  |          |       |
|--|----------|-------|
| CRIME/INCIDENT LOCATION<br>SPRINGFIELD AVENUE, SPRINGFIELD NJ 07081 - NORTH SIDE OF BRIDGE<br>OVER RT 22 | EMPLOYER | PHONE |
|--|----------|-------|

|                                      |                 |              |  |                                   |
|--------------------------------------|-----------------|--------------|--|-----------------------------------|
| MUNICIPALITY<br>SPRINGFIELD TOWNSHIP | COUNTY<br>UNION | CODE<br>2017 | PERSON REPORTING CRIME<br>MINITEE, PO. JAMAL | DATE AND TIME<br>01/23/2011 10:23 |
|--------------------------------------|-----------------|--------------|--|-----------------------------------|

|                            |                 |   |                       |
|----------------------------|-----------------|---|-----------------------|
| TYPE OF PREMISES<br>Street | WEAPONS - TOOLS | ADDRESS<br>UNION COUNTY POLICE DEPARTMENT - 300 NORTH AVE.<br>EAST 908-654-9800, WESTFIELD NJ 07090 | PHONE<br>908-654-9800 |
|----------------------------|-----------------|---|-----------------------|

MODUS OPERANDI

|                    |              |             |              |                   |             |                               |                            |               |
|--------------------|--------------|-------------|--------------|-------------------|-------------|-------------------------------|----------------------------|---------------|
| VEHICLE<br>Damaged | YEAR<br>2003 | MAKE<br>JAG | MODEL<br>X-T | BODY TYPE<br>4 DR | COLOR<br>BK | REG. PLATE-STATE<br>NPH56X NJ | VIN <i>★</i><br>[REDACTED] | VEHICLE VALUE |
|--------------------|--------------|-------------|--------------|-------------------|-------------|-------------------------------|----------------------------|---------------|

|                       |          |         |      |          |      |       |
|-----------------------|----------|---------|------|----------|------|-------|
| VALUE STOLEN PROPERTY | CURRENCY | JEWELRY | FURS | CLOTHING | AUTO | MISC. |
|-----------------------|----------|---------|------|----------|------|-------|

|                              |                       |                |                    |                  |
|------------------------------|-----------------------|----------------|--------------------|------------------|
| TOTAL VALUE STOLEN<br>\$0.00 | TOTAL VALUE RECOVERED | TELETYPE ALARM | TECHNICAL SERVICES | TECHNICAL AGENCY |
|------------------------------|-----------------------|----------------|--------------------|------------------|

|                  |     |     |                    |
|------------------|-----|-----|--------------------|
| WEATHER<br>CLEAR | SIC | NIC | ASSISTING AGENCIES |
|------------------|-----|-----|--------------------|

|                     |            |               |                        |                               |            |              |
|---------------------|------------|---------------|------------------------|-------------------------------|------------|--------------|
| NO. OF ACCUSED<br>0 | ADULT<br>0 | JUVENILE<br>0 | STATUS CRIME<br>ACTIVE | STATUS CASE<br>PENDING ACTIVE | UCR STATUS | DATE CLEARED |
|---------------------|------------|---------------|------------------------|-------------------------------|------------|--------------|

**NARRATIVE**

DETAILED TO PEARL VISION PARKING LOT ON US RT. 22 EAST IN SPRINGFIELD NJ IN REGARDS TO A DISABLED VEHICLE. UPON ARRIVAL ON SCENE, I MET MICHELLE CAPUTO, DL# [REDACTED] *Driver's License # redacted* MRS. CAPUTO STATED THAT WHILE DRIVING NJ. REGISTRATION NPH-56X, ON THE NORTHEBOUND SIDE OF SPRINGFIELD AVE. BRIDGE THAT GOES OVER RT. 22, SHE DROVE INTO A LARGE POTHOLE THAT CAUSED HER PASSENGER SIDE FRONT TIRE TO GO FLAT. I GAVE MRS. CAPUTO THE TELEPHONE NUMBER TO RISK MANAGEMENT AND INFORMED HER THAT I WILL MAKE DOCUMENTATION OF THE LOCATION OF THE POTHOLE. UNION COUNTY POLICE DESK MADE NOTIFICATION TO UNION COUNTY ROADS DEPARTMENT OF THIS HAZARDOUS ROAD CONDITION AND THEY STATED THEY WOULD RESPOND TO LOCATION TO FILL THE POTHOLE.

|                            |      |                              |  |      |           |
|----------------------------|------|------------------------------|--|------|-----------|
| NAME<br>P/O MINITEE, JAMAL | 6055 | DATE OF REPORT<br>01/23/2011 | REVIEWED BY<br>SERCEANT SCHUSTER, GARY | 6036 | SIGNATURE |
|----------------------------|------|------------------------------|--|------|-----------|

THIS CLAIM FORM MUST BE FILED WITHIN NINETY (90) DAYS OF ACCIDENT OR OCCURRENCES OR YOU MAY FORFEIT YOUR RIGHTS. (N.J.S. 59:B-1, et seq.)

CLAIM FOR DAMAGES AGAINST: COUNTY OF UNION

Forward To: County of Union  
10 Elizabethtown Plaza  
Elizabeth, NJ 07207

CLAIMANT:

DIGGS-YOUNG, IHSAD  
LAST NAME FIRST MIDDLE

03/13/1998  
DATE OF BIRTH

  
STREET ADDRESS

Same  
MAILING ADDRESS

  
CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER

Single  
MARITAL STATUS

N/A  
NUMBER OF DEPENDENTS

  
HOME PHONE

N/A  
WORK PHONE

1. If notices and correspondence in connection with this claim are to be sent to a person other than the claimant, complete Item No. 2

Brian C. Freeman, Esq.  
NAME

26 Journal Square, Suite 1205  
MAILING ADDRESS

Jersey City, New Jersey 07306  
CITY, STATE, ZIP CODE

Relationship to claimant: Attorney-at-Law (X) or

RELATIONSHIP

2. (a) The occurrence or accident which gave rise to this claim.

February 10, 2011  
DATE

3:00 P.M.  
TIME A.M. P.M.

(b) Describe the location or place of the accident or occurrence.

Rahway  
MUNICIPALITY

On a Vogel Bus Company school bus  
EXACT LOCATION OF OCCURRENCE  
(Indicate exact street address)

DESCRIPTION OF ACCIDENT

At approximately 3:00 p.m., on February 10, 2011, claimant was forced off the school bus in Rahway by the bus driver who was threatening him with a crowbar. Claimant was left by himself in an area he was not familiar with.

(c) Draw a diagram of the area of the incident. Label all intersecting streets. Indicate "North" by an arrow. Indicate house numbers where applicable. Mark "X" at exact spot of occurrence and state distance in feet from nearest intersecting streets if spot is no otherwise identifiable. Indicate public property.

(d) State the name and address of the City agency or agencies that you claim caused your damage/injury.

City of Rahway

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

Unknown at this time, discovery continuing.

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

(f) State the negligence or wrongful acts of the City agency and City employees which caused your damage.

Improper behavior of bus driver  
\_\_\_\_\_  
\_\_\_\_\_

(g) State the name and address of all witnesses to the accident or occurrence.

Unknown at this time, discovery continuing.

(h) State the name and address of all police officers and police departments who investigated the accident.

Rahway Police Department, P.O. Marie Deering, Badge No. 1125, Rahway, NJ

3. (a) Claim for damages (check appropriate box):  
(X) Personal Injury                      ( ) Property Damage

( ) Other

If other, explain in detail: \_\_\_\_\_

(b) If you claim personal injury:

(1) Describe your injuries resulting from this accident or occurrence.

Claimant suffered a panic attack/psychological affect because of the trauma of this incident.

(2) Do you claim permanent disability resulting from this injury?

Yes.

(3) For each hospital, doctor, or other practitioner rendering treatment, examination, or diagnostic service, state:

| Name of Hospital or Doctor | Address           | Date of Treatment | Amount of charges to date | Amount paid or payable by other sources such as as insurance |
|----------------------------|-------------------|-------------------|---------------------------|--|
| <u>Clark First Health</u>  | <u>Rahway, NJ</u> | <u>D/A</u>        | <u>To be advised</u>      | <u>To be advised</u>   |

(4) If you claim lost wages or income as a result of injury, state:

N/A  
NAME OF EMPLOYER

\_\_\_\_\_  
ADDRESS OF EMPLOYER

N/A  
YOUR OCCUPATION

\_\_\_\_\_  
DATE EMPLOYED AT THIS JOB

N/A  
RATE OF PAY

\_\_\_\_\_  
DATE OF ABSENCES FROM WORK

N/A  
TOTAL LOST WAGES TO DATE

\_\_\_\_\_  
IF STILL OUT OF WORK EXPECTED  
DATE OF RETURN

NOTE: If your claimed loss of income arises from self-employment or sources other than wages, attach an itemization showing basis of your calculation of lost time.

(5) Set forth any and all other losses claimed by you.

To be advised

(c) If you claim property damage: Not applicable.

(1) Describe the property damaged.

N/A

(2) The present location and time when the property may be inspected.

(3) Date property acquired.

(4) Cost of Property \$

(5) Value of property at time of accident.

(6) Description of Damage.

(7) Attach each estimate of repair costs to this form.

(8) Set forth in detail the list claimed by you for property damage.

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

5. The amount of the claim \$

6. Have you made a claim against anyone (including insurance companies) 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 claim.

7. Are any of the losses or expenses claimed herein covered by any policy of insurance? \_\_\_\_\_

To be advised \_\_\_\_\_

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


8. Have you received or agreed to receive any money from anyone for the damages claimed herein?       No       If so, set forth the details of such agreement. \_\_\_\_\_

9. The following items must be submitted with this notice.

- (1) Copies of itemized bills for each medical expense or other losses and expenses claimed.
- (2) Full copies of all appraisals and estimates of property damaged claimed by you.
- (3) Copies of all written reports of all expert witnesses and treating physicians.
- (4) 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 statement made herein is willfully false, that I am subject to punishment provided by law.

DATED: 2/18/11

  
\_\_\_\_\_  
CLAIMANT OR PERSON FILING ON  
BEHALF OF CLAIMANT

HIPAA AUTHORIZATION FORM

I, \_\_\_\_\_ hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person or class of persons or facility is authorized to make the requested disclosure:

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

2. The following person or class or persons may receive disclosure of protected health information about me.

3. The specific information that should be released is: All records of any and all treatment, including but not limited to, ambulance reports, hospital records, emergency room reports, x-rays and x-ray reports, MRI films, ALL reports or copies thereof relating to any insurance claims, medical examinations, consultations, confinements and treatments and to permit them to inspect and make copies or abstracts thereof. You are also authorized to provide any psychiatric drug and/or alcoholic information, if applicable, for the specific date of and the range of years through.

4. I understand that if my medical records contain information related to sexually transmitted or communicable disease, AIDS or test for infection with human immunodeficiency virus (HIV), that my signing this document authorize the release of that information.

5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by the federal privacy regulations.

6. I may revoke this authorization by notifying the Law Offices of Brian C. Freeman, LLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

7. The authorization expired on \_\_\_\_\_, or upon the occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: settlement of the lawsuit.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING:**

X \_\_\_\_\_  
Signature of Individual

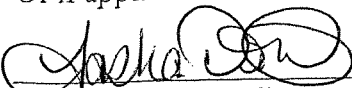
\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

OR

\_\_\_\_\_  
Social Security Number

Or if applicable:

  
\_\_\_\_\_  
Signature of Guardian

02-16-11  
\_\_\_\_\_  
Date



ALL INFORMATION REQUESTED IN THIS FORM MUST BE PROVIDED SO THAT FAIR AND FULL DISCLOSURE OF INFORMATION NECESSARY TO THE ORDERLY AND EXPEDIENT ADMINISTRATIVE DISPOSITION OF THE CLAIM MAY BE HEARD. UNDER THE SCHEME OF THE NEW JERSEY TORT CLAIMS ACT, A GOVERNMENTAL ENTITY IS AFFORDED AT LEAST SIX MONTHS FROM THE DATE OF THE RECEIPT OF A COMPLETE ANSWERS TO ALL QUESTIONS AND/OR THE WITHHOLDING OF INFORMATION MAY RESULT IN FORFEITURE OF THE CLAIMANT'S RIGHTS. (N.J.S. 59:8-1, et seq.)

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INVESTIGATIVE REPORT

RAHWAY POLICE DEPT

|   |  |   |  |  |  |   |  |   |  |  |                          |   |  |
|---|--|---|--|--|--|---|--|---|--|--|--------------------------|---|--|
| 1. Complaint Number<br><b>2011-002990</b>   |  | 2. Mun. Code<br><b>NJ0201300</b>                  |  | 3. Phone Number<br><b>(732) 827-2200</b> |  | 4. UCR                                    |  | 21. Prosecutor's Case Number  |  | 22. Criminal Case Number<br><b>2011-002990</b>           |                          |   |  |
| 5. Crime/Incident<br><b>55 - JUVENILE INCIDENT</b>  |  |   |  | 6. NJS<br><b>55</b>                      |  |   |  | 23. Victim's Name (First, Middle, Last)<br><b>IHSAD DIGGS-YOUNG</b> |  |  |                          |   |  |
|   |  |   |  | Social Security Number                   |  |   |  | 24. D.O.B.  |  | 25. Sex<br><b>M</b>                                      | 26. Race<br><b>BLACK</b> |   |  |
| DATE  |  | 7. Between<br><input checked="" type="checkbox"/> |  | 8. Hour<br><b>1450</b>                   |  | 9. Day<br><b>Thu</b>                      |  | 10. Mo.<br><b>Feb</b>   |  | 11. Date<br><b>10</b>                                    |                          |   |  |
| AND   |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| TIME  |  |   |  | <b>1330</b>                              |  | <b>Thu</b>                                |  | <b>Feb</b>  |  | <b>10</b>  |                          |   |  |
| 13. Crime/Incident Location<br><b>343 BROOKFIELD PL</b>   |  |   |  | 14. Municipality<br><b>RAHWAY, NJ</b>    |  |   |  | 15. County<br><b>UNION</b>  |  | 18. Code   |                          | 28. Employer                                |  |
| 17. Type of Premises<br><b>HIGHWAY</b>  |  |   |  | 18. Code<br><b>01</b>                    |  | 19. Weapons - Tools                       |  | 20. Code  |  | 29. Person Reporting Crime/Incident<br><b>JOAN DIGGS</b> |                          | 30. Date and Time<br><b>2/10/2011 15:49</b> |  |
| 32. Modus Operandi<br><b>DRIVER OF BUS RAISED A CROWBAR AND TOLD CHILD TO GET OFF BUS</b>   |  |   |  | 31. Address                              |  |   |  |   |  |  |                          | Phone                                       |  |
| 33. Vehicle   |  | 34. Year  |  | 35. Make                                 |  | 36. Body Type                             |  | 37. Color   |  | 38. Registered Number & State                            |                          | 39. Serial Number or Identification         |  |
| VALUE<br>STOLEN<br>PROPERTY   |  | 40. Currency                                      |  | 41. Jewelry                              |  | 42. Furs                                  |  | 43. Clothing  |  | 44. Auto   |                          | 45. Misc.                                   |  |
| 46. Total Value Stolen  |  | 47. Total Value Recovered                         |  | 48. S.C.I.C. #                           |  | 49. Computer Msg.                         |  | 50. Technician - Agency   |  |  |                          |   |  |
| 51. OLN #   |  | 52. LIS   |  | 53. N.C.I.C. #                           |  | 57-62. Evidence Found                     |  |   |  |  |                          |   |  |
| 54-56. Witness  |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| List Accused. List and Identify Additional Victims: Describe Perpetrators or Suspects: Action Taken include Findings and Observations of Investigator: Physical Evidence Found: Where By Whom: Disposition and Technical Services Performed; Interview of Victims; Persons Contacted; Accused Suspects' List; Describe Stolen Property; Value; Court Action; Attached Statements. |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| 63. No. of Accused<br><b>1</b>  |  | 64. Adult<br><b>1</b>                             |  | 65. Juvenile<br><b>0</b>                 |  | 66. Status Crime                          |  | 67. Status Case<br><b>OPEN</b>                                      |  | 68. UCR Status<br>Month Yr.                              |                          | 69. Date Cleared                            |  |
| 70. Name  |  | Address   |  | 71. Age                                  |  | 72. Sex                                   |  | 73. Race  |  | 74. DOB  |                          |   |  |
| [REDACTED] DIGGS, TASHA   |  | [REDACTED]  |  | 34                                       |  | F   |  | BLACK   |  | 10/01/1976   |                          |   |  |
| [REDACTED] VOGEL, BUS CO  |  | [REDACTED]  |  |  |  |   |  | BLACK   |  |  |                          |   |  |
| [REDACTED] JULIETA-LINARES, FELIX   |  | [REDACTED]  |  |  |  | M   |  | WHITE   |  |  |                          |   |  |
| SIR:  |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| ON 02-10-2011 AT APPROXIMATELY 1549 HOURS, I WAS DISPATCHED TO [REDACTED] TO  |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| INVESTIGATE A JUVENILE INCIDENT. UPON ARRIVAL, I SPOKE TO MRS DIGGS WHO STATED THAT HER GRANDSON,   |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| [REDACTED] WAS ON THE SCHOOL BUS TODAY WHEN THERE WAS A FIGHT BETWEEN TWO OTHER STUDENTS. SHE FURTHER   |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| STATED THAT THE BUS DRIVER PICKED UP A CROW BAR AND THREW [REDACTED] OFF THE BUS SOMEWHERE ACROSS ST  |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| GEORGES AVENUE.   |  |   |  |  |  |   |  |   |  |  |                          |   |  |
| 75. Name<br><b>PO MARIE DEERING</b>   |  | 76. Badge Number<br><b>1125</b>                   |  | 77. Page 1 of<br>2 Pages                 |  | 78. Date of Report<br><b>Feb 10, 2011</b> |  | 79. Reviewed By<br><b>SGT JEFFREY KOSTY</b>                         |  |  |                          |   |  |
| Signature _____   |  |   |  | 80.                                      |  | 81.                                       |  | 82.   |  |  |                          |   |  |

-Redactions not indicated By asterisk were pre-redacted By submitter.

RAHWAY POLICE DEPT

Complaint Number

111-002990

21. Prosecutor's Case Number

22. Criminal Case Number

2011-002990

SPOKE TO IHSAD, WHO WAS VISIBLY SHAKEN AND CRYING, WHO STATED THAT HE WAS NOT FIGHTING ON THE BUS AND WAS TRYING TO GET THROUGH OR BREAK UP THE FIGHT, WHEN THE BUS DRIVER DESCRIBED AS A HISPANIC MALE, PICKED UP A CROW BAR AND RAISED IT AND TOLD HIM TO GET OFF THE BUS. HE STATED THAT HE THEN GOT OFF THE BUS. IHSAD ADVISED ME THAT HE WAS AFRAID THAT IF HE DIDN'T GET OFF THE BUS HE WAS GOING TO GET HIT BY THIS DRIVER. IHSAD WAS NOT SURE OF THE EXACT LOCATION WHERE HE WAS THROWN OFF THE BUS, BUT STATED IT WAS THE SECOND STOP FROM THE SCHOOL. IHSAD WAS ASKED IF THE DRIVER PUT HIS HANDS ON HIM AT ALL, AND HE STATED NO.

MRS DIGGS ADVISED ME THAT [REDACTED] MOTHER, TASHA, WAS ON HER WAY HOME AND WAS COMPLETELY INFORMED OF THE INCIDENT.

I ADVISED MRS DIGGS COMPLAINT PROCEDURES AND ALSO TO NOTIFY THE SCHOOL OF THE INCIDENT.

I THEN RESPONDED TO BREZA BUS COMPANY AND WAS ADVISED THAT VOGEL BUS COMPANY HANDLES THE RAHWAY SCHOOL SYSTEM.

I THEN RESPONDED TO HQ AND CONTACTED THE VOGEL BUS COMPANY AND SPOKE TO THE SUPERVISOR, LAURA, WHO ADVISED ME OF THE DRIVER INFORMATION. LAURA ALSO ADVISED ME THAT THE BUS COMPANY WOULD BE PLACING THE DRIVER ON SUSPENSION PENDING AN INVESTIGATION.

I THEN SPOKE TO MRS TASHA DIGGS AND SHE ADVISED ME THAT SHE WAS AT THE RAHWAY MIDDLE SCHOOL SPEAKING TO MRS HALL ABOUT THE INCIDENT.

SHE ALSO ADVISED ME THAT THE TWO CHILDREN THAT WERE FIGHTING ON THE BUS WERE [REDACTED] AND [REDACTED].

[REDACTED] MRS DIGGS STATED THAT SHE WOULD INFORM MRS HALL OF THIS AS WELL.

MRS DIGGS IS INTERESTED IN PURSUING COMPLAINTS AGAINST THE BUS DRIVER.

RESPECTFULLY SUBMITTED

75. Name  
PO MARIE DEERING

76. Badge Number  
1125

77. Page 2 of  
2 Pages

78. Date of Report  
Feb 10, 2011

79. Reviewed By  
SGT JEFFREY KOSTY.

Signature \_\_\_\_\_

80.

81.

82.

# 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 11 2011  
ADMINISTRATION BUILDING  
ELIZABETH, NJ

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

1. Claimant:

Tierro Lauren A

Last Name, First, Middle

3/22/00

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 2/13/11 Time approx 11.30 AM

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

Union  
Municipality

overpass of Rt 22.  
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.

was in lane going over Rt 22, at top of overpass

huge pothole tire blew out immediately

left car there overnight till Monday AM - coasted into Delta gas station wasn't driveable

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

( ) Personal Injury (  ) Property Damage

( ) Other - Explain in detail New tire, bumper screws.

reflectn from impact

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



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.

estimate from insurance

\_\_\_\_\_

B. The amount of the claim.

1387.84

15.00 flat repair to put on donut to get to tire Co.

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

Union, NJ

\_\_\_\_\_

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.

huge pot holes

\_\_\_\_\_

\_\_\_\_\_

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.

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

Lia Fierro (Same as mine)  
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 Springfield, NJ  
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.

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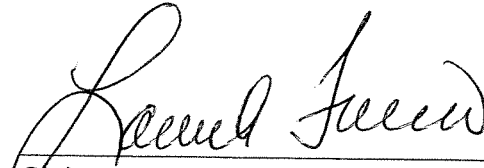
14. Are any of the losses or expenses claimed herein covered by any policy of insurance.

all except 500.00 deductible  
15.00 to put on donut  
bought tire \$1 (Delta gas station) 200.82

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:

3/7/11



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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.

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

WR  
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.

\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

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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):

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

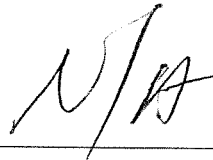
My health information is to be released to:

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: \_\_\_\_\_

1 Case Number: 2011-1112  
 2 Police Dept of: City of Springfield  
 3 Station/Precinct: 15  
 10 Crash Occurred On: S. Springfield Ave, S 315  
 11 Speed Limit: 35  
 12 Route No.: 13 Milepost: 18 Speed Limit: 15  
 14 15 16: At Intersection with: Schaffernoth Pl  
 17 Cross Road Name: Schaffernoth Pl  
 4 Date of Crash: 02/13/11  
 5 Day of Week: Su  
 6 Time (use 2400 hrs): 1154  
 7 Municipality Code: 2017  
 8 Total Killed: 0  
 9 Total Injured: 0  
 19 Ramp: 20 Route/Name: 21 Latitude: 22 Longitude:  
 23 Veh No: 1  
 24 Policy No: 999492851051  
 25 Ins Code: 903  
 26 Driver's First Name: Lauren A. Fierro  
 27 Number and Street: [Redacted]  
 28 City: [Redacted] State: AZ Zip: 85038  
 31 State: NJ 32 Drivers License No: [Redacted] 33 DOB: 03/22/60 34 Expires: 04/14  
 35 Owner's First Name: Chase Manhattan Aut Fin Cor  
 36 Number and Street: PO Box 29214  
 37 City: Phoenix State: AZ Zip: 85038  
 38 Make: Maz 39 Model: 6 40 Color: BK 41 Year: 10 42 Plate No: ZXY86N 43 State: NJ  
 44 VIN: [Redacted] 45 Expires: 06/13  
 46 Vehicle Removed To:  Driven  Left at Scene  Towed  Impound  Disabled  
 47 Authority:  Owner  Driver  Police  
 48 Alcohol/Drug Test: Given:  No  Yes  Refused  
 Type:  Breath  Blood  Urine  
 Results: 0.00%  Pending  
 49 Hazardous Material: On Board  Spill  Name or Placard No.:  
 50 Carrier No.:  USDOT  Other \*  
 51 Commercial Vehicle Weight:  ≤ 10,000 lbs  10,001 - 26,000 lbs  ≥ 26,001 lbs  
 52 Carrier name:  
 134 Crash Diagram (NOT TO SCALE):  
 S. Springfield Ave (Bridge)  
 Schaffernoth Pl. → Veh! ← pothole  
 78 Alcohol/Drug Test: Given:  No  Yes  Refused  
 Type:  Breath  Blood  Urine  
 Results: 0.00%  Pending  
 79 Hazardous Material: On Board  Spill  Name or Placard No.:  
 80 Carrier No.:  USDOT  Other \*  
 81 Commercial Vehicle Weight:  ≤ 10,000 lbs  10,001 - 26,000 lbs  ≥ 26,001 lbs  
 82 Carrier name:  
 135 Crash Description: DI stated she was traveling on South Springfield Ave when she struck a large pothole in the roadway. Damage to VI consisted of a flat tire, broken fog lamp and cracked side marker light. All damage was on the passenger's side front of the vehicle.  
 136 Damage To Other Property: None  
 137 Charge:  Multiple Charges  
 138 Summons No.: 139 Charge:  Multiple Charges  
 140 Summons No.:  
 141 Officer's Signature: P.O. Michael [Signature]  
 142 Badge No.: 1055  
 143 Reviewed By: [Signature] 144 Case Status:  Pending  Complete

|   | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | Names & Addresses of Occupants - If Deceased, Date & Time of Death |
|---|----|----|----|----|----|----|----|----|----|----|----|----|----|--|
| A | 1  | 01 | 01 | -  | 50 | F  | -  | -  | 1  | 09 | 04 | -  | -  | Driver 1   |
| B | 1  | 03 | 01 | -  | 22 | F  | -  | -  | 1  | 09 | 04 | -  | -  | Lia Fierro (same as DI)  |
| C |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
| D |    |    |    |    |    |    |    |    |    |    |    |    |    |  |
| E |    |    |    |    |    |    |    |    |    |    |    |    |    |  |

NJTR-1 (R1/08)  
 #2011-1112

Police Copy

**TRAVELERS**  
**Keep and Close Claim Office**  
Supplement Hotline Call 888-299-7456 Prompt 2  
PO Box 4947  
Orlando, FL 32802-4947  
(877)411-0768

**ESTIMATE OF RECORD**

Written By: Gary Blanco [REDACTED] 02/15/2011 10:35 AM  
Adjuster: David Gabris (860)756-9523

*Cell # redacted*

**Insured:** LAUREN FIERRO  
**Owner:** LAUREN FIERRO  
**Address:** [REDACTED]  
**Evening:** [REDACTED]  
**Cellular:** [REDACTED]

**Claim #** HHP0141001  
**Policy #** PT5010A9799492851051  
**Date of Loss:** 02/13/2011 at 12:00 PM  
**Type of Loss:** Collision  
**Point of Impact:** 1. Right Front

**Inspect** INSD WORK  
**Location:** 105 ROUTE 46 W  
LODI, NJ 07644-0000

**Day:** [REDACTED]  
OTHER

**Repair** OWNERS CHOICE  
**Facility:** NJ

2 Days to Repair  
**License #**

2010 MAZD 6 GT 4-2.5L-FI 4D SED BLACK Int:

|                           |                        |                          |                       |
|---------------------------|------------------------|--------------------------|-----------------------|
| <b>VIN:</b> [REDACTED]    | <b>Lic:</b> ZYX86N NJ  | <b>Prod Date:</b>        | <b>Odometer:</b> 9364 |
| Air Conditioning          | Rear Defogger          | Tilt Wheel               |                       |
| Cruise Control            | Telescopic Wheel       | Intermittent Wipers      |                       |
| Keyless Entry             | Alarm                  | Steering Wheel Controls  |                       |
| On Board Computer         | Tinted Glass           | Dual Mirrors             |                       |
| Console/Storage           | Overhead Console       | Electric Glass Sunroof   |                       |
| Traction Control          | Stability Control      | Fog Lamps                |                       |
| Clear Coat Paint          | Metallic Paint         | Power Steering           |                       |
| Power Brakes              | Power Windows          | Power Locks              |                       |
| Power Driver Seat         | Power Mirrors          | Power Trunk/Gate Release |                       |
| AM Radio                  | FM Radio               | Stereo                   |                       |
| Search/Seek               | CD Changer/Stacker     | Premium Radio            |                       |
| Auxiliary Audio Connectio | Satellite Radio        | Anti-Lock Brakes (4)     |                       |
| Driver Air Bag            | Passenger Air Bag      | Head/Curtain Air Bags    |                       |
| Front Side Impact Air Bag | Leather Seats          | Bucket Seats             |                       |
| Heated Seats              | Automatic Transmission | Overdrive                |                       |
| Aluminum/Alloy Wheels     |                        |                          |                       |

| NO. | OP.  | DESCRIPTION         | QTY | EXT. PRICE | LABOR | PAINT |
|-----|------|---------------------|-----|------------|-------|-------|
| 1#  |      | Vehicle is drivable | 1   |            |       |       |
| 2#  |      |                     |     |            |       |       |
| 3   |      | FRONT BUMPER        |     |            |       |       |
| 4   | Repl | Bumper cover        | 1   | 249.21     | 2.0   | 3.0   |
| 5   |      | Add for Clear Coat  |     |            |       | 1.2   |
| 6   |      | Add for fog lamps   |     |            | 0.3   |       |

**ESTIMATE OF RECORD**  
2010 MAZD 6 GT 4-2.5L-FI 4D SED BLACK Int:

| NO.   | OP.  | DESCRIPTION                          | QTY | EXT. PRICE    | LABOR | PAINT |
|-------|------|--------------------------------------|-----|---------------|-------|-------|
| 7#    |      |                                      |     |               |       |       |
| 8     |      | FRONT LAMPS                          |     |               |       |       |
| 9     | Repl | RT Signal lamp assy                  | 1   | 8.22          | 0.2   |       |
| 10#   |      |                                      |     |               |       |       |
| 11    |      | FENDER                               |     |               |       |       |
| 12    | Repl | RT Fender liner w/17x7 & 18x8" wheel | 1   | 51.48         | 0.6   |       |
| 13    | Repl | RT Fender liner fastener             | 2   | 3.16          |       |       |
| 14#   |      |                                      |     |               |       |       |
| 15    |      | WHEELS                               |     |               |       |       |
| N 16* | Subl | RT/Front Wheel, alloy 17" +25%       | 1   | <u>161.25</u> | Xm    |       |
| 17#   |      |                                      |     |               |       |       |
| 18    |      | TIRES                                |     |               |       |       |
| N 19* | Repl | SUMO 215/55R17 HTR A/S P01 94V       | 1   | <u>204.00</u> | 0.3   |       |
| 20**  | Repl | A/M FLEX ADDITIVE                    | 1   | 6.00          |       |       |
| 21**  | Repl | A/M CAR COVER EXTERIOR               | 1   | 5.00          | 0.2   |       |
| 22#   | Subl | Two/Thrust Wheel Alignment           | 1   | 49.95         | T     |       |
| 23#   | Rpr  | Clean & Detail                       |     |               | 0.5   |       |
| 24    |      | OTHER CHARGES                        |     |               |       |       |
| 25#   |      | Hazardous Waste                      | 1   | 3.00          |       |       |

Subtotals ==> 741.27 4.1 4.2

Line 16 : ALLOY WHEEL REPAIR *call ph#* [REDACTED] JONATHAN  
 Line 19 : ins'd changed tire, price includes mount and balance

Estimate Notes:  
 CONTACT WITH INS'D 2-15-2011, INSPECTION SCHEDULED FOR 2-15-2011  
 VEHICLE INSPECTED AT POB LODI   
 APPRAISAL DISCUSSED AND E-MAILED TO MRS. FIERRO, UPL ON 2-15-2011  
 SUPPLEMENTS MUST BE PRE-APPROVED BY STAFF APPRAISER OR MAY BE DENIED  
 PLEASE CALL 1-888-299-7456 TO SCHEDULE A SUPPLEMENT RE-INSPECTION   
 REPAIRS MUST BE AUTHORIZED BY VEHICLE OWNER  
 ALL SUPPLEMENTS NEED TO BE CALLED IN BEFORE / FULLY DOCUMENT ALL SUPPLEMENTS  
 POSSIBLE ADDT'L DAMAGE, REINSPECTION AFTER TEAR DOWN \*\*\*\*\*  
 VEHICLE FALLS UNDER OEM GUIDELINES

|                |                       |            |
|----------------|-----------------------|------------|
| Parts          |                       | 527.07     |
| Body Labor     | 4.1 hrs @ \$ 45.00/hr | 184.50     |
| Paint Labor    | 4.2 hrs @ \$ 45.00/hr | 189.00     |
| Paint Supplies | 4.2 hrs @ \$ 28.00/hr | 117.60     |
| Sublet/Misc.   |                       | 211.20     |
| Other Charges  |                       | 3.00       |
| -----          |                       |            |
| SUBTOTAL       |                       | \$ 1232.37 |
| Sales Tax      | \$ 1068.12 @ 7.0000%  | 74.77      |

**ESTIMATE OF RECORD**

2010 MAZD 6 GT 4-2.5L-FI 4D SED BLACK Int:

|                       |            |
|-----------------------|------------|
| TOTAL COST OF REPAIRS | \$ 1307.14 |
| ADJUSTMENTS:          |            |
| Deductible            | 500.00     |
| TOTAL ADJUSTMENTS     | \$ 500.00  |
| NET COST OF REPAIRS   | \$ 807.14  |

All supplements must be pre-approved by Travelers. Please call 888-299-7456 (prompt 2)

Supplement repair charges may be subject to rejection unless approved by Travelers prior to repairs.

This instrument is not an authorization to repair. Repair must be pre-authorized by the vehicle owner.

Vehicle owner maintains the right to repair vehicle at a repair facility of their choice.

Please present this estimate to the repair facility prior to repairs.

IF YOU ELECT TO USE YOUR OWN REPAIR FACILITY THAT IS ENGAGED IN THE BUSINESS OF AUTO BODY REPAIR, YOU ARE REQUIRED BY LAW TO UTILIZE A DULY LICENSED REPAIR FACILITY. PLEASE BE ADVISED THAT FIRST TRENTON INDEMNITY COMPANY AND/OR TRAVELERS AUTO INSURANCE COMPANY OF NEW JERSEY IS PROHIBITED BY LAW FROM NEGOTIATING, ADJUSTING OR SETTLING AN AUTOMOBILE DAMAGE CLAIM WITH AN UNLICENSED FACILITY.

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

THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN LIKE, KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO REPLACEMENT PARTS AVAILABLE FROM THE ORIGINAL MANUFACTURER.



**ESTIMATE OF RECORD**

2010 MAZD 6 GT 4-2.5L-FI 4D SED BLACK Int:

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide ARH5441, CCC Data Date 01/04/2011, 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.

CCC Pathways - A product of CCC Information Services Inc.

02/15/2011 at 10:35 AM  
101022

HHP0141001  
25y60d77

**ESTIMATE OF RECORD**

2010 MAZD 6 GT 4-2.5L-FI 4D SED BLACK Int:

TIRE PARTS SUPPLIERS

19 SUMO 215/55R17 HTR A/S P01 94V

Price: \$ 204.00

Etd Discount Tire Ctr

Phone: (973) 625-4800

329 Route 46

FAX:

Denville, NJ 07834

**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:

Hunter MARY  
Last Name, First, Middle

7/6/31  
Date of Birth

Street Address/Mailing Address

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 2-2-2011 Time 6 AM

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

Union County  
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.

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

- Personal Injury     Property Damage  
 Other - Explain in detail

Car Damage

Back Window Tree Limb Broke with Ice Broke  
BACK WINDOW, the whole window out cost - 500.00

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.

500.00 Deductible ALL State INSURANCE

E. Value of property at time of accident.

CLAIM# 019-078.7044

500.00 Damage

1. Description of damage.

G. Has the damage been repaired?

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

Quality Auto glass  
Repaired by

2-2/2011  
When

ALL State  
500. Deductible  
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.

500.00 deductible  
Because of a Ice Tree fell on Back Window

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.

\_\_\_\_\_ no one \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

BURROUGH S. L  
Name of Police Officer

PLPD NJ  
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.

\_\_\_\_\_  
None  
\_\_\_\_\_

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

I had to pay the first 500.00 deductible

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

All State  
Name & Address of Ins. Co.

909765107  
Policy Number

Benefits Paid or Payable

AK State PO Box 40047  
Name & Address of Ins. Co.

Roanoke Va  
Policy Number

24022  
0047

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.

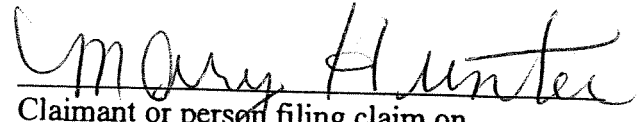
D. A letter from your employer verifying your lost wages. If self employed, a statement showing the calculation of your claimed lost income. None

E. Completed "Authorization for Release of Health Information", see attached form. None



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:

  
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

NO  
HEALTH  
problem

**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:** \_\_\_\_\_



PLAINFIELD POLICE DIV  
PLAINFIELD, NJ

MARY HUNTER  
CLAIM # 019-078-7044

INCIDENT # / REPORT #  
11002920 / 1

OFFICER  
BURROUGHS, L

RANK  
POLICE OFFICER

REVIEW STATUS  
REJECTED

**INCIDENT #11002920 DATA**

As Of 02/02/2011 11:09:08

**BASIC INFORMATION**

CASE TITLE

PROPERTY DAMAGE

LOCATION

[REDACTED]

APT/UNIT #

[REDACTED]

DATE/TIME REPORTED

02/02/2011 06:56:16

DATE/TIME OCCURRED

On or after 02/02/2011 06:00

INCIDENT TYPE/OFFENSE

NON-CRIMINAL POLICE REPORT

**PERSONS**

ROLE

VEHICLE OWNER

NAME

HUNTER, MARY

SEX

RACE

AGE

DOB

59

07/06/1951

PHONE

(HOME) [REDACTED]

(CELL) [REDACTED]

ADDRESS: [REDACTED]

[ NO OFFENDERS ]

**VEHICLES**

ROLE

DESTROYED/DAMAGED/VANDALIZED

TYPE

YEAR

2009

MAKE

PONTIAC

MODEL

G-6

COLOR

BLUE

REG #

ZKY82L

STATE

NJ

STOLEN \$

REC CODE

DATE REC

REC \$

REC BY

[ NO PROPERTY ]

**OFFICER REPORT: 11002920 - 1 / BURROUGHS, L (POLICE OFFICER)**

DATE/TIME OF REPORT

02/02/2011 06:56:16

TYPE OF REPORT

INCIDENT

REVIEW STATUS

REJECTED

**NARRATIVE**

02 February 2011

Responded to [REDACTED]

(city) on a report of property.

At arrival, I observed that a large tree limb had fallen on the hood of the vehicle described due to the inclement weather; extreme icy

redacted as to security computer exception in OPRA.

Law enforcement software.

APCS

http:// [REDACTED]

2/3/2011

WWW.QUALITYAUTOGLASSNJ.COM  
 2300 SOUTH CLINTON AVENUE  
 SOUTH PLAINFIELD NJ 07080  
 (908)754-2652 Fax:(908)756-8527  
 Tax# 22-2903846

Order:58392

Date:02/02/2011

Insurance:

LYNX SERVICES FROM PPG  
 9901 W. 87TH STREET  
 OVERLAND PARK KS 66212

Insured:

MARY HUNTER  
 SO. PLFD. SHOP

Scheduled:02/02/2011

Cell: ~~XXXXXXXXXX~~ cell ph# redacted  
 per OPRA

Csr: MJG Tech: PO: Terms: C.O.D  
 Claim: 382910230 Loss-Date: 02/02/2011 Authorized: ALLSTATE

Bill-To Acct: 476

Vehicle: 2009 PONTIAC G6 4 DOOR SEDAN

Qty Part / Description

1 DB10860GT - Back Window Green Tint (w/Attch) (UPPER & LOWER MOULDINGS)(Heated)(Solar)  
 2.00 HAH000004 - Adhesive (2.00)

Job Location:

We guarantee your new installation to be free of leaks and defects in workmanship for one year from date of invoice. When you choose Quality Auto Glass you can rest assured your car or truck is in the hands of professionals who are committed to doing the job right. If you are not satisfied for any reason, call us. All repairs must be done at one of our locations so that the repair can be tested and completed correctly.

Thank you.

Signature \_\_\_\_\_

Insured Totals:

| <u>Tax</u> | <u>Deductible</u> | <u>Total</u> | <u>Payments</u> | <u>Balance</u> |
|------------|-------------------|--------------|-----------------|----------------|
| 0.00       | 500.00            | 500.00       | 0.00            | 500.00         |

Insured Copy

vers:7.1.56 Page: 1 of 1