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

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

CRIME DETAILS

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

NAME DETAILS

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