SUPPLEMENTAL CLAIM

INSTRUCTIONS: Statute of Limitations is one year, if death is involved, two years. Give complete information and **attach all requested documentation** and any other information to substantiate your claim. The burden of proof rests with the claimant. Failure to provide complete information may affect the decision of your claim. **ALL CLAIMS MUST BE SIGNED AND NOTARIZED**. Submit two complete sets to: **STATE BOARD OF ADJUSTMENT, ALABAMA STATE CAPITOL, THIRD FLOOR EAST WING, MONTGOMERY, AL 36130-1435. PHYSICAL MAILING ADDRESS: 600 DEXTER AVENUE, SUITE 302, MONTGOMERY, AL 36104.**

Do not write in this space

CLAIM NO.: _____
SUPPLEMENT NO.:_____

If a SUPPLEMENT to a previously filed claim, give Claim No.:_____

_____
Name of Department/Agency

1. **Name & Mailing Address of Claimant:** _____

_____

Home Telephone: _____ Business Telephone: _____

Social Security/Federal I.D. No. (Required for issuance of state check): _____

If injured party is a minor (under 19 years of age), CLAIM MUST BE SIGNED AND FILED BY PARENT OR GUARDIAN AS CLAIMANT. Give name and age of minor and the name and relationship of person with whom minor lives.

_____

2. **Claimant's Attorney** (if representing claimant on this claim):_____

Mailing Address: _____

_____ Zip: _____ Telephone _____
Note: All correspondence and communication will be with claimant's attorney.

3. **IS CLAIM MADE FOR:** (Complete only those parts which apply to this claim.)

(A) UNINSURED MEDICAL EXPENSES? ☐ Yes ☐ No

Amount: $ _____ Do you have insurance? ☐ Yes ☐ No Company: _____

All medical expenses must be submitted to your insurance company: **Attach documentation to support the amount claimed, such as itemized bills and insurance company statement (s) showing the expenses have been filed and the amount paid or payable by insurance.**

(B) PERMANENT DISABILITY? ☐ Yes ☐ No

Amount: $ ____

Describe: ____

Attach detailed statement by a doctor or vocational expert describing extent of disability

Rate of pay at time of accident/injury: **$ ____________________** **Attach verification from employer.**

(C) LOST WAGES AND/OR COMPENSATION FOR LEAVE USED? ☐ Yes ☐ No

Amount: $__________________ for ____________________ hrs./days/weeks/etc.

Period (dates) for which claim is made: _______________________________

Rate of pay at time of accident/Injury: $ ______________

Attach doctor excuse for dates missed from work. Attach verification of dates and rate of pay from employer.

(D) MISCELLANEOUS/OTHER EXPENSES? ☐ Yes ☐ No

Amount: $____

Explain: ____

____

Attach documentation to substantiate.

4. **TOTAL AMOUNT CLAIMED: $**________________________

This amount must be stated

No part of this claim as been assigned by me and no amount has been paid or received by me in payment for any damagesinjury complained of herein except as set out as follows: (List amounts received from insurance or any other sources.)

____

5. Signature of claimant/representative:______________________________________

Must bear original signature (not a machine copy) of claimant or his/her representative.

►►

STATE OF ________________________________}

COUNTY OF ______________________________} **AFFIDAVIT**

Before me, a Notary Public in and for said state and county, personally appeared ____________________________ who being made known to me, and being informed of the contents of this petition and the statements by him/her therein, and being duly sworn, says such statements are true and correct.

Sworn and subscribed before me this ______________ day of __________________, 20 _________.

____

Signature and Seal of Notary Public