Valley Transportation Authority

Solutions that move you

Dear Claimant:

In order to file a claim for Damages against Santa Clara Valley Transportation Authority, you must fill out the enclosed claim form as completely as possible (in accordance to Government Code Section 910). Be sure to include your name, current address and telephone number in the space provided. If the damages are less than $10,000, please include the basis of the computation of the amount claimed.

As required by government Code 910, a claim must be filed with Santa Clara Valley Transportation Authority within six months of the incident. Please use additional paper if needed.

Completed claims must be mailed or hand delivered to (no faxes will be accepted):

Santa Clara Valley Transportation Authority
Attention: Board Secretary's Office
3331 N First Street Bldg B
San Jose, CA 95134-1906

After your claim is processed our claims adjuster will contact you to discuss your claim.

Warning: It is a criminal offense to file a false claim (Penal Code Section 72)

Enclosure: Claim for Damages Form

Valley Transportation Authority

Solutions that move you

SANTA CLARA VALLEY TRANSPORTATION AUTHORITY
3331 North First Street, San Jose, California, 95134-1906

CLAIM FOR DAMAGES

(This constitutes compliance with Government Code. 910-910.2)

Please Print or Type:

The name and post office address of the claimant:

Claimant's Legal First Name: _____

Claimant's Legal Last Name: _____

Post Office Address: _____

Telephone: (Home) _____

Telephone: (Business/Cell) _____

The post office address to which the claimant desires notices to be sent.

Post office address: _____

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that Santa Clara Valley Transportation Authority report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist Centers for Medicare and Medicaid Services and other insurance plans to properly coordinate payment of benefits among plans so that (your) claims are paid promptly and correctly. We are asking you to answer the following questions so that we may comply with this law.

Are you presently, or have you ever been, enrolled in Medicare Part A or B? YES ◯ Or No ◯

IF YES, please provide the following information:

Medicare Claim Number: _____

Date of Birth: _____

Social Security Number: _____

Gender: M ◯ or F ◯

Valley Transportation Authority

Solutions that move you

Claimant Name: _____

CLAIM FOR DAMAGES

The date, place and other circumstances of the occurrence or transaction that gave rise to the claim asserted:

Date of Incident/Accident: _____

Time of Incident/Accident: _____ ◯AM ◯PM

Location of Incident/Accident
Street/City: _____

A general description of the indebtedness, obligation, injury, damage or loss incurred so far as it may be known at the time of presentation of the claim. Please state the known facts surrounding the loss and use additional paper if needed.

Valley Transportation Authority

Solutions that move you

Claimant Name: _____

CLAIM FOR DAMAGES

The name or names of the VTA employee or employees causing the injury, damage, or loss, if known.

If the claim totals less than $10,000, the amount claimed as of the date of presentation of the claim: _____

If the amount exceeds $10,000, this claim would be: ○ Less than $25,000 (Limited Civil Case) ○ More than $25,000

Claimant: _____ Date: _____

Signature/Print Name

Attorney or Representative: _____ _____

Date:

Signature/Print Name