



7772 N. Palm Ave.
 Fresno, CA 93711
www.fcera.org
 (559) 457-0681 p.
 (559) 457-0318 f.

CLAIM FOR DAMAGES

THIS CLAIM MUST BE SUBMITTED BY MAIL OR PERSONAL DELIVERY <i>Presentation of a false claim is a felony (CA Penal Code Section 72)</i>						
NOTE: Claims for bodily injury or death, damage to personal property or damage to growing crops must be filed not later than six (6) months after the occurrence out of which the claim/claims arose. All other claims must be filed not later than one (1) year after the occurrence out of which the claim/claims arose. (CA Government Code Section 911.2).						
DIRECTIONS: File the original and one (1) copy of this form with Fresno County Employees' Retirement Association, Retirement Administrator, 7772 N. Palm Ave., Fresno, CA, 93711						
Name of Claimant (Injured or damaged party)	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Last, First, Middle <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 2px;">Date of Birth</td> <td style="width: 35%; padding: 2px;">Social Security Number</td> <td style="width: 40%; padding: 2px;">CA Driver License</td> </tr> </table>		Date of Birth	Social Security Number	CA Driver License
Date of Birth	Social Security Number	CA Driver License				
Home Address and Telephone Number	Number/Street/City/State/Zip Code Telephone Number					
Business Address and Telephone Number	Number/Street/City/State/Zip Code Telephone Number					
Where would you like notices sent?	<input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Attorney					
When did the injury or damage occur?	Month/Day/Year	Day of Week	Time of Day <input type="checkbox"/> AM <input type="checkbox"/> PM			
Where did the injury or damage occur?	Street address, intersection or other location					
How did the injury or damage occur?	 <div style="text-align: right; font-size: small;">Attach additional sheets if necessary.</div>					
PLEASE CONTINUE AND COMPLETE SECOND PAGE OF THIS CLAIM FORM						



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Names and telephone numbers of witnesses	<i>Attach additional sheets if necessary.</i>		
Names of FCERA Employees involved	<i>Attach additional sheets if necessary.</i>		
Police Agency and Police Report Number			
What action or inaction of FCERA or its employee(s) caused your injury or damages?	<i>Attach additional sheets if necessary.</i>		
What injuries or damages did you suffer?	<i>Attach additional sheets if necessary.</i>		
Total amount claimed:	\$ _____		
DIRECTIONS: Sign and date this Claim for Damages below. NOTE: If the signer is <u>not</u> the claimant, please indicate relationship of signer to the claimant (e.g., parent, attorney, etc.) and include full address.			
_____ SIGNATURE	_____ DATE	_____ RELATIONSHIP TO CLAIMANT	
_____ PRINT NAME	_____ TELEPHONE NUMBER		
_____ STREET ADDRESS	_____ CITY	_____ STATE	_____ ZIP CODE
DIRECTIONS: Attach to this completed and signed form any bills for medical treatment and expenses, and any estimates or bills for repair/replacement of damaged personal property.			