



# PERSONAL INJURY CLAIM FORM

**SUBMIT FORM TO:** City of Mason, Customer Service, 201 W. Ash Street, Mason, MI 48854  
Phone: 517-676-9155 / FAX: 517-676-1330 Email: info@mason.mi.us

## TO BE FILLED OUT BY CLAIMANT

Full Legal Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

### DESCRIPTION OF DAMAGE

In this section, provide as much detail as you can. Be specific on the nature of the injury (i.e. sprain, fracture, etc.). Be specific on the body part and side of body injured. Then provide as much detail as to the cause of this injury. Please note **you MUST provide the following:** 1) Medical documentation showing an injury occurred; 2) Proof of the expense you wish to be reimbursed; 3) Your health insurance policy information showing the coverages you have (also known as your Schedule of Benefits); 4) Your Insurance Explanation of Benefits; 5) If possible, photos of the injury and/or location/cause of the injury; 6) Police report or police report number (if applicable). **Failure to provide this information will delay the claim process and could result in a denial of your claim. Please note, providing this information does not guarantee payment to you. The City of Mason and its insurance carrier reviews each claim individually.**

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_  AM  PM

Did Incident Occur at Home Address:  Yes  No - If No, then where: \_\_\_\_\_

Witness to Incident (Name and Number): \_\_\_\_\_

Did you file a police report:  Yes  No **Describe in detail how and why the injury happened. (Use additional paper if needed.)**

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

### AS PART OF THE CLAIM PROCESS YOU MUST CONTACT YOUR MEDICAL INSURANCE COMPANY TO VERIFY ANY COVERAGE.

Did you make a claim against your insurance  YES  NO

If yes, please provide their contact details: \_\_\_\_\_

Please state the total dollar amount you are claiming from the City of Mason? \_\_\_\_\_  
(You are **REQUIRED** to provide documents supporting the dollar amount)

### CLAIMANT DECLARATION AND SIGNATURE

**By signing below, I hereby swear the information provided above and attached to this claim is true and accurate under penalty of law.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CITY OF MASON USE ONLY

Date Received: \_\_\_\_\_ Substantiated:  YES  NO Date Sent to MMRMA: \_\_\_\_\_

Action Taken:  APPROVED  DENIED  CLOSED Amount Approved: \_\_\_\_\_

Revised 01.10.2024 (Clerk/HR, CMA)