

ATBE AUTOMOBILE FUND
CLAIM FOR PROPERTY DAMAGE / PERSONAL INJURY

Instructions: Primarily for use by individuals and entities asserting an ATBE Claim (not a subrogation claim), this two page form is to be **FULLY COMPLETED and SUBMITTED TO the ATBE COVERED PARTY along WITH ALL SUPPORTING DOCUMENTATION** to claim damages to property and damages for personal injury as a result of an automobile incident with an ATBE Member board of education owned or operated Covered Automobile. This Claim form must be (1) signed and (2) notarized (the information that you provide verified as truthful under oath before a notary public). Give complete information on both pages and attach ALL documentation to prove your Claim, including but not limited to the documents specified in this form. **Without a fully completed and signed Claim form and ALL supporting documentation ATBE may not be able to fully review and respond.** Failure to follow all instructions, including but not limited to failure to provide the fully completed and signed Claim form and all supporting documentation in a single, comprehensive submission may result in the matter not being reviewed by ATBE, no response from ATBE, or delay administration by ATBE. PRINT or TYPE

RETURN this FORM and ALL DOCUMENTS to the ATBE Covered Party (e.g., BOARD OF EDUCATION)
Do NOT submit directly to ATBE. Initial submissions directly to ATBE do NOT qualify as an ATBE Claim and will NOT be reviewed. Return ONLY to the ATBE Covered Party.

Board of Education against which you are making this claim _____

Date of Incident _____ Location of Incident _____

Claimant Information

Name _____ Date of Birth _____ Gender _____

Enrolled in Medicare: Yes No If yes, Medicare (HICN or SSN) _____

Enrolled in Medicaid: Yes No

Parent/Legal Guardian Name and Relationship (if Claimant is Minor) _____

Address (Street, City, State, ZIP Code) _____

Telephone: Home _____ Work _____ Cell _____

Email Address _____ (Note: communications from ATBE will be in writing, via email or mail)

Facts of Claim

Statement of Facts (For property damage claim describe your property and how the damage to your property occurred. For personal injury claim describe how your injury occurred. Attach additional pages if necessary. Attach a copy of documents that evidence and prove your claim.)

Describe the property damage or personal injury (Attach additional pages if necessary. For property damage attach at least TWO estimates of the cost of repair. If at least two estimates of the cost of repair are not attached provide a written explanation as to why. For personal injury attach a report from your doctor that describes your injuries and treatment, including the type and amount of medical services provided relating to your claimed injury.)

Who is the record title owner of the vehicle? (Provide a copy of the vehicle title or registration.) _____

Is there a lien on the vehicle title? If yes, who is the lienholder? _____

What is the 1) year, 2) make, 3) model, 4) color, 5) mileage, AND 6) vehicle identification number (VIN) of your vehicle?

ATBE AUTOMOBILE FUND
CLAIM FOR PROPERTY DAMAGE / PERSONAL INJURY

What is the lowest estimate for repair to your vehicle/property? _____

Where is your vehicle located? _____

Have you incurred storage charges? Are you requesting reimbursement or approval for ATBE to pay storage charges? If yes, at what facility and what is the rate or cost? (*Attach an itemized invoice or quote to substantiate expenses.*) _____

Have you incurred charges for a rental vehicle? Are you requesting reimbursement or approval for ATBE to reimburse for a rental vehicle due to the claimed damage to your vehicle? If yes, how many days have you rented or will you be renting a vehicle, from which company, and at what rate or cost? (*Attach an itemized invoice or quote to substantiate expenses.*) _____

Applicable to claims of damage to your vehicle due to an automobile incident with a Member board of education owned or operated vehicle: Following approval by ATBE, ATBE will reimburse a maximum of \$25.00 per day not to exceed a total cost of \$175 incurred prior to approval by ATBE for storage of your damaged vehicle. Such storage charges must accrue for storage of the damaged vehicle at a licensed storage or repair facility. Following approval by ATBE, ATBE will reimburse a maximum of \$25.00 per day not to exceed a total cost of \$175 for reasonable and necessary costs of a rental vehicle incurred prior to approval by ATBE. Except as previously noted, it is agreed that ATBE is not responsible for and will not reimburse or pay any costs or charges relating to renting a vehicle, storage of a vehicle, or repair of a vehicle that accrue prior to your providing notice of your Claim to the Covered Party (e.g., board of education) and approval for such charges is granted by ATBE.

What is the total amount you are claiming for personal injury/medical expenses? _____
(*Attach documentation to substantiate claim, including itemized bills from your medical provider for medical expenses.*)

Have you filed for insurance coverage under your personal automobile or other insurance or liability policy?
 Yes No If yes, provide the 1) name, 2) telephone number, and 3) address of your insurance carrier or coverage provider, AND 4) confirm/clarify that you filed a claim for administration and coverage as opposed to simply reporting the incident: _____

I hereby affirm the information contained on this two page form and all attachments hereto to be complete, true, and accurate. I understand that the language in this form in no way obligates ATBE or the Covered Party to reimburse or compensate me for any incurred or expected costs or charges arising from the subject automobile incident. I understand that the information is provided to accurately coordinate the damaged or injured party's claim(s), including but not limited to, if the claimant is a Medicare beneficiary, coordination with Medicare and to meet mandatory reporting obligations under Medicare law. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), requires that liability insurers (including self-insurers) and no-fault insurers report specific information about Medicare beneficiaries who have other coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans. I understand that if I am a Medicare beneficiary or the parent/legal guardian of the injured party who is a Medicare beneficiary, and I do not provide the requested Claimant Information, including Medicare HICN or social security number(s), I may be violating obligations to assist Medicare in coordinating benefits to pay claims correctly and promptly. I agree that electronic transmittal of this executed document shall be legal and binding. With respect to information contained herein and all supporting documentation, I understand and agree that there is no expectation of privacy or confidentiality and no duty imposed to protect from or notify of disclosure.

Signature of Claimant or Parent/Legal Guardian, if Claimant is a Minor **Date**

STATE OF ALABAMA)
_____ County)

I, the undersigned authority in and for said county and state hereby certify that the person whose name is signed above and who is known to me, acknowledged and affirmed before me on this day that all of the above stated information is complete, true, and correct and they signed the same voluntarily on the day the same bears date. Given under my hand this ____ day of _____, 20__.

SEAL

Notary Public, Printed Name _____
My Commission Expires: _____

Date Received by Covered Party (e.g., board of educ) _____ Received by _____