OCFA Clerk of the Authority
Received: _____

OCFA Risk Management
Received: _____

ORANGE COUNTY FIRE AUTHORITY
CLAIM FOR DAMAGES TO PERSON OR PROPERTY

A claim against the Orange County Fire Authority (OCFA) must be filed with the Clerk of the Authority within **six (6)** months after the incident or event occurred. Be sure your claim is against the OCFA and not another entity. Where space is insufficient, please use additional paper and identify the paragraph being answered by number.

Completed claim form and related documents and photos must be hand delivered or mailed to:

Orange County Fire Authority
1 Fire Authority Road
P.O. Box 57115
Irvine, CA 92619-7115

Please Print

Section I: Claimant Information

Name of Claimant: _____
First Name | Middle Initial | Last Name

Address: _____
Street Address | City/State | Zip Code

Telephone No. _____
Home | Cell | Work

E-Mail Address: _____

Section II: Claim Information

Date of Occurrence: Time of Occurrence:
Location: _____

Circumstances giving rise to this claim: _____

_____

_____

_____

_____

Describe the indebtedness, obligation, injury, damage or loss incurred so far as you now know.

If known, provide the name(s) of the OCFA employee(s) who you believe caused the injury or damage.

Provide dollar amount of claim and explain how the dollar amount was computed. Please attach receipts/estimates. If amount claimed exceeds $10,000, please indicate whether the claim would be a "limited jurisdiction civil case" (under $25,000) or "general jurisdiction civil case" (over $25,000).

If this claim relates to an automobile accident, please provide the following information:

Auto Insurance Company: Telephone No.

Auto Insurance Company Address:

Auto Insurance Policy No.

Insurance Broker/Agent Name: Telephone No.

Vehicle License No. Vehicle Make/Model/Year:

Driver License No. State Issued: Expiration Date:

Section III: Medicare Secondary Payer Act.

The Medicare Secondary Payment Act is a federal law that became effective January 9, 2010. OCFA is required to report all claims involving payments for bodily injury and/or medical treatments to Medicare. If you are seeking medical damages you may be required to provide

your social security number prior to any payment by OCFA or OCFA will be unable to process your claim.

If the claim involves medical treatment for a claimed injury, please provide the name, address and telephone number of any physicians or hospitals providing treatment. If applicable, please attach copies of any medical bills, reports or similar documents supporting your claim.

WARNING: Presentation of a false claim may be considered a crime. Pursuant to CCP§1038, OCFA may seek to recover all costs of defense in the event an action is filed which is later determined not to have been brought in good faith with reasonable cause.

Section IV: Representative/Attorney Information (Must be completed if claim is being filed by attorney or authorized representative.)

Name of Attorney/Representative (*please print*)

Mailing Address:

Street Address City/State Zip Code

Area Code/Telephone No.

E-Mail Address:

Section V: Notice and Signature

Signature of Claimant Date

Signature of Attorney/Representative Date