RR TRMN 3000 / 3014 ✓

AUTO LIABILITY

CLAIM AGAINST THE CITY OF PORTLAND

** for auto accidents involving a City vehicle **

RECEIVED
MAR 16 2022
CITY OF PORTLAND
RISK MGMT

File Number: 2022-012074-22

A claim must be filed with **City of Portland Risk Management** *within 180 days after the occurrence of the incident or event.*
Normal business hours: Monday through Friday, 8:00am to 5:00pm. Closed on official holidays.
Claims received during regular business hours will be recorded on the date received.
Faxed or emailed claims received after business hours will be recorded on the next working day.
Please be sure *your claim is against the* **City of Portland**, *not another public entity.*
Where space is insufficient, please use additional paper and identify information by section number and letter.
Completed forms may be mailed, emailed, faxed, or hand-delivered to:
Risk Management/Liability, 1120 S.W. Fifth, Room 709, Portland, OR 97204-1912, Ph: 503-823-5101, Fax: 503-823-6120
LiabilityClaims@portlandoregon.gov

1. Claimant (Circle: Mr. Mrs. Ms. Miss) mr /kenneth Plippen Date of Birth [redacted]

a. Address 2135 SE 122 Apt 8 City Portland State OR Zip 97233

b. Home Phone _____ Business Telephone _____ Cell Phone 503-933-6768

c. Occupation Sales d. Marital Status: Single ( ) Married (X) Divorced / Widowed ( )

If married, name of spouse Charleta Hastings

d. E-mail address [redacted]

2. If claim involves a vehicle: a. Year, make and model 03 F15

b. License Plate Number [redacted] Driver's License Number [redacted] State OR

c. At time of accident, were you (check all that apply): Owner ✓ Driver ____ Passenger ____ N/A ____

d. Name and address of owner if different from claimant: (1. Above) _____

e. Name & address of driver if different from claimant: (1. Above) _____

Phone number of Driver _____ Date of Birth of Driver _____

f. Names / addresses / phone #s of all occupants of vehicle at the time of the incident Ø

3. Insurance: a. Wi[illegible] insures the damaged vehicle? Ø

b. Policy Number _____ Claim Nu[illegible]

c. Name and address of your insurance agent or adjuster _____

Type of Coverage _____

4. Occurrence or event from which the claim arises:

a. Date of incident 2-18-22 b. Exact location 33rd & ~~Harman~~ Holman

c. Were you injured? Yes ____ No X Was anyone else injured? Yes ____ No X

(If there was no injury, please state "No Injuries") NO Injuries

d. Nature and extent of any injuries N/A

e. If you were injured, name / phone / address of your treating doctor _____

_____

f. ***We are required to report all claims for injuries to Medicare/Medicaid Services** *

If you were injured please provide the following: Social Security #: _____

Medicare/Medicaid Beneficiary? Yes ___ No ___

g. Were you on the job at the time of the incident? Yes ____ No _____

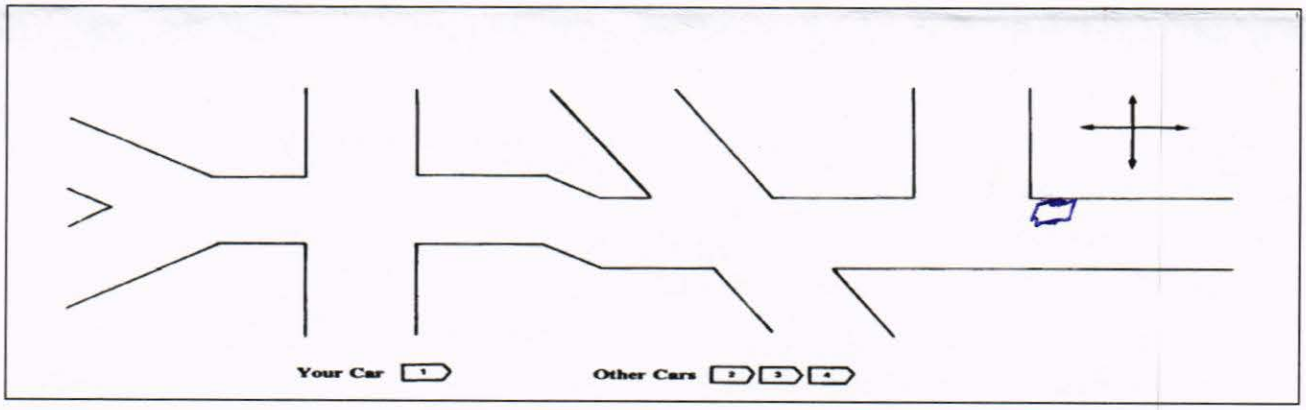
If yes, what is the name / phone / address of your employer? _____

_____

h. Name of City of Portland Driver _____ City vehicle license# _____

Names / Addresses / Phone Numbers of any witnesses to the incident: _____

_____



5. **Description of Incident:** What happened? Give a full account, including the speed of each car and the direction each car was traveling. Please use the diagram above.

my ~~the~~ vehicle was parked I found a note that you left it was on ~~the~~ Rear ~~bumb~~ bumper an Quarter panel on the Truck was damage.

6. **Damages claimed:**

a. Amount claimed as of this date _____

b. Estimated amount of future costs _____

c. Total amount claimed 1500

WARNING: IT IS A CRIMINAL OFFENSE TO FILE A FALSE CLAIM! (ORS 162.085)

I have carefully read the statements made in this claim, including any attached sheets, and they are true. I understand and acknowledge that all statements made in this claim are made to a public servant of the City of Portland, and that the statements are in connection with an application for a benefit from the City of Portland.

3/12/22
DATE

CLAIMANT'S SIGNATURE