



AUTO LIABILITY CLAIM AGAINST THE CITY OF PORTLAND

* for auto accidents involving a City vehicle *



File Number: 2024-015804-22

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) State Farm Mutual Ins Co a/s/o Francisco Mora Date of Birth n/a
 - a. Address PO Box 106172 City Atlanta State GA Zip 30348-6172
 - b. Home Phone n/a Business Telephone (877) 787-8276 ext 2443 Cell Phone n/a
 - c. Occupation n/a d. Marital Status: n/a Single () Married () Divorced / Widowed ()
 - If married, name of spouse n/a
 - d. E-mail address [REDACTED]
2. **If claim involves a vehicle:** a. Year, make and model 2000 Toyota Corolla
 - b. License Plate Number unk Driver's License Number n/a State unk
 - c. At time of accident, were you (check all that apply): Owner n/a Driver RECEIVED Passenger N/A
 - d. Name and address of owner if different from claimant: (1. Above) n/a
 - e. Name & address of driver if different from claimant: (1. Above) n/a
 - f. Names / addresses / phone #s of all occupants of vehicle at the time of the incident n/a
3. **Insurance:** a. What company insures the damaged vehicle? State Farm Mutual Ins Co
 - b. Policy Number [REDACTED] Claim Number [REDACTED]
 - c. Name and address of your insurance agent or adjuster Stephanie Easterbrook
 - PO Box 106172 Atlanta, GA 30348-6172 Type of Coverage n/a
4. **Occurrence or event from which the claim arises:**
 - a. Date of incident 3/29/2024 b. Exact location 3350 Portland Rd NE in Salem, Oregon
 - c. Were you injured? n/a Yes No Was anyone else injured? Yes No
 - (If there was no injury, please state "No Injuries") Driver Ana Mora and passenger Ignacio Galvan sustained injuries
 - d. Nature and extent of any injuries Airbags deployed causing minor injuries both driver and passenger

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

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

If you were injured please provide the following: Social Security #: n/a

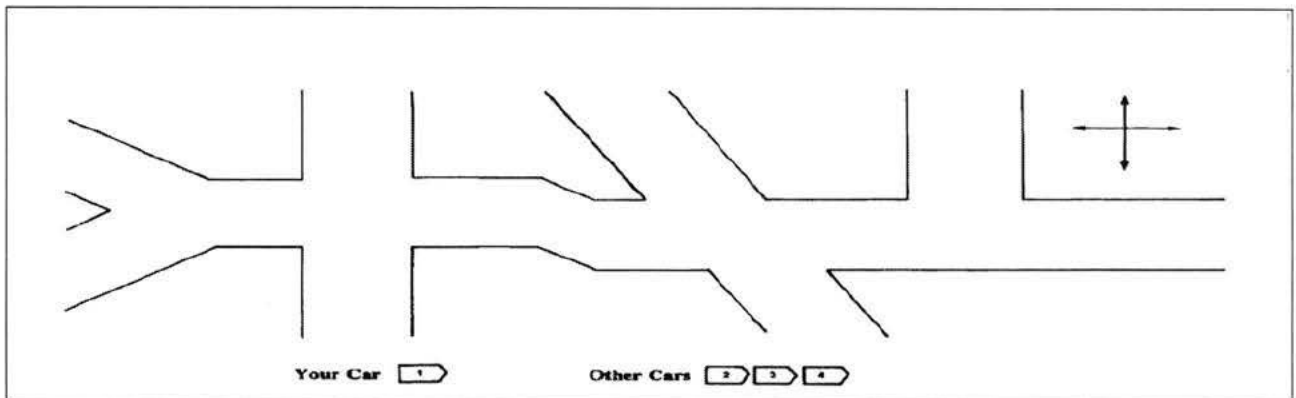
Medicare/Medicaid Beneficiary? Yes n/a No

g. Were you on the job at the time of the incident? Yes n/a No

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

h. Name of City of Portland Driver Tyke Murdock City vehicle license# [REDACTED]

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



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.

The insured driver was northbound in left lane; City tow truck driver crossed middle middle lane, went to the farthest right lane. City tow truck then took sharp left turn causing the collision.

6. **Damages claimed:**

a. Amount claimed as of this date \$5,787.70

b. Estimated amount of future costs n/a

c. Total amount claimed \$5,787.70

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.

9/13/2024

DATE

State Farm Mutual Ins Co a/s/o Francisco Mora

Stephanie Easterbrook

CLAIMANT'S SIGNATURE

Stephanie
Easterbrook

Digitally signed by
Stephanie Easterbrook
Date: 2024.09.13
14:38:11 -05'00'

Medical

600/050 - Med Pay/ PIP	\$2,251.70
Party A	\$258.97 (Ignacio)
Party B	\$1,992.73 (Ana)
041/045 - Uninsured Motorist BI	\$
Other Medical:	\$

Based on the assessment of liability between the parties, State Farm Mutual Automobile Insurance Company is seeking 100% of the Total Claim Amount listed above. The amount payable to State Farm Mutual Automobile Insurance Company for this loss is \$5,787.70.

Our insured's vehicle was declared a total loss. Here is our total loss breakdown, showing how we arrived at the amount State Farm paid for our insured's vehicle:

Settlement:	
Base Price:	\$3,228.00
+Taxes:	\$0.00
+Fees:	\$136.00
-Deductible:	\$500.00
-Owner Retained Amt:	\$
Total Paid:	\$2,864.00

Please remit payment of this claim, or contact us at (877) 787-8276 Ext. 2443 to discuss settlement. Please include our claim number on the payment. If you reimburse our insured's deductible directly, please advise us at time of payment. Thank you for your cooperation.

In order to assist you in evaluating and processing the subrogation claim we are asserting, we may provide nonpublic personal information about our customer. We are sharing this information to effect, administer, or enforce a transaction authorized by the consumer. However, you are neither authorized nor permitted to: (1) use the customer information we provided for any purpose other than to evaluate and process the subrogation claim, or (2) disclose or share the customer information we provide for any purpose other than to evaluate and process the subrogation claim.

If you have questions or need assistance, call us at (877) 787-8276 Ext. 2443.

Sincerely,

Stephanie Easterbrook
Claim Associate
(877) 787-8276 Ext. 2443
Fax: (866) 231-9276

For your protection, when emailing State Farm, please do not include sensitive personal information such as Social Security Number, credit/debit card number (financial account number), driver's license number, or health/medical information in an email. Please contact us at (877) 787-8276 Ext. 2443 to discuss sensitive information.

State Farm Mutual Automobile Insurance Company

Enclosure(s): **ENCLOSURE(S)**

Other insurance carriers with access to st8.fm/oic-self-service can check for claims and review claim status online, including some payment details such as issue date, status, and amount. They can also view principal damage information and upload documents for an open claim. All insurance carriers can file an auto claim online on statefarm.com/claims.

Express

Extremely Urgent

106/1040
RISK

RECEIVED
SEP 10 2024
CITY OF PORTLAND
RISK MANAGEMENT

SHIPPING MANAGER
(972) 969-7255
STATE FARM INSURANCE COMPANIES
8225 BENT BRANCH DRIVE
IRVING TX 75063

1.0 LBS LTR 1 OF 1

SHIP (503) 823-5265
TO: CITY OF PORTLAND RISK MANAGEMENT
1120 SW 5TH AVE RM 709
PORTLAND OR 97204-1965



OR 972 9-12



UPS NEXT DAY AIR SAVER

TRACKING #: 1Z 21X W15 13 9074 0887

1P



BILLING: P/P
REF1: SR17320166
REF2: 37-65J1-20W



1202-03360
GREEN 588RE

918.A.000 Z105 34.5V 08/2024

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