RR

PKDI

GENERAL LIABILITY
CLAIM AGAINST THE CITY OF PORTLAND

** for damages to persons or property **

File Number: 2025001145GL

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. 5th Ave., Suite 1040, Portland, OR 97204-1912, Ph: 503-823-5101,
Fax: 503-823-6120 LiabilityClaims@portlandoregon.gov

1. Claimant (Circle: Mr. Mrs. Ms. Miss) Carolyn Lee Date of Birth [redacted]

a. Address 9734 NW Miller Hill Dr. City Portland State OR Zip 97229

b. Home Phone 503-292-3341 Business Telephone _____ Cell Phone 503-706-7130

c. Occupation retired d. Marital Status: Single ( ) Married ( ) Divorced or Widowed (x)

If married, name of spouse _____

d. E-mail address [redacted]

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

b. License Plate Number _____ Driver's License Number _____ State _____

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) _____

3. Occurrence or event from which the claim arises:

a. Date _____ Time _____ Circle AM / PM

b. Place (exact and specific location) _____

c. Specify the particular occurrence, event, act, or omission by the City that you believe caused the injury or damage (use additional paper if necessary): I am submitting this claim, because my original layoff date was June 30. To ensure I had insurance coverage, I set up Medicare Park B to start July 1. The timing of the layoff changed, so I am actually covered by City of Portland health insurance until August 31. I was ~~advised by Social Security and Medicare to NOT cancel Medicare Part B, because they couldn't ensure~~ that they could reinstate coverage in a timely fashion and I didn't want to risk NOT having coverage. I am seeking reimbursement for $370, the cost for two months of Medicare Premium bill.

d. State how the City of Portland or its employees were at fault: The City of Portland changed the date of the layoff and the health insurance coverage was extended. Therefore, I am seeking financial reimbursement for loss of funds, due to my having to pay out of pocket ~~for two months of Medicare Part B.~~

e. Were you on the job at the time of the accident? Yes____ No _____

If yes, what is the name / phone number of employer _____

City of Portland Risk Management 8/20/2025

4. **Description:** Describe the injury, property damage or loss so far as is known at the time of this claim.
Financial loss in the amount of $370.

5. ***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 ___

6. **Give the name(s) of the City employee(s) and/or City Bureau causing the damage or injury** _____

7. **Name and address of any other person injured** _____

8. **Name and address of the owner of any damaged property if different from claimant** _____

9. **Damages claimed:**

a. Amount claimed as of this date: $ $370

b. Estimated amount of future costs: $ _____

c. Total amount claimed: $ $370

d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.): _____
Please see attached photo of paid Medicare Premium Bill. The total bill was $555, but I am only seeking reimbursement of $370, which covers July and August.

10. **Names, addresses / phone #s of all witnesses** _____

11. **Any additional information that might be helpful in considering your claim** _____
Being laid off and not receiving a paycheck is another reason I can use the $370 reimbursement.

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 I know them to be true of my own knowledge, except as to those matters stated upon information or belief and to such matters I believe the same to be 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.

Date: August 20, 2025

Carolyn Lee

Claimant's Signature

Carolyn Lee

Print Name

City of Portland Risk Management 8/20/2025