

GENERAL LIABILITY **CLAIM AGAINST THE CITY OF PORTLAND**

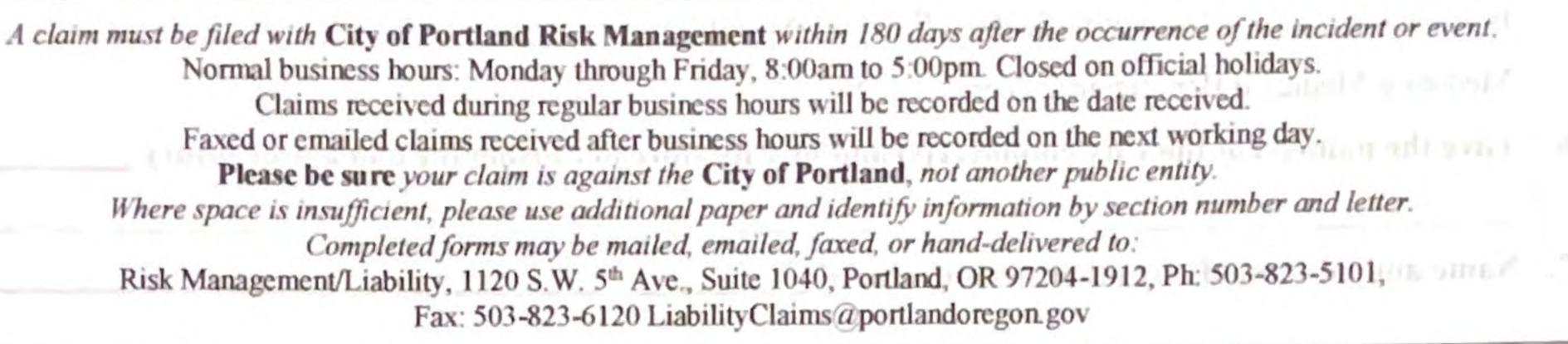
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* for damages to persons or property *

2025000575GL File Number:



1. Claimant (Circle Mr. Mrs. Ms. Miss) THOWAS BENNETT Date of Birth a Address 6435 NE 8TH AVE City PORTLAND State OR Zip 9724 Home Phone ______ Business Telephone _____ Cell Phone _____ 480 -634 -0239 b. Occupation SELF - EMPLOYED d. Marital Status: Single () Married () Divorced or Widowed () C. If married, name of spouse KATE BENGOICT

d. E-mail address		THE DISC TOTAL COMPANY AND A DESCRIPTION OF THE DES
If claim involves a vehicle: a	Year, make and model 2016 TOYOTA PRI	VS and a not a set R. b
	Driver's License Number	
	you (check all that apply) Owner: X Driver X I	
d. Name and address of own	er if different from claimant (1 Above)	10. Numer, addresses (p
Occurrence or event from w		
a. Date 3/16/2025	Time 10:15 Circ	le AM (PM)
b. Place (exact and specific le	ocation) SONTHBOUND ON 82ND Q WE	BSTER ST.
c. Specify the particular occu	rrence, event, act, or omission by the City that you beli	ieve caused the injury or
damage (use additional pap	perifnecessary): POTHOLE BIG ENOUGH TO	POP A TIRE
	UNDERSIDE OF A CAR WAS REPORTED	
AND IT WAS NOT	FIXED WITHIN 10 DAYS. IT SLAMME	THE YAR 10
HARD ALL Y PASS	ENGERS WERE EXTREMELY RATTLED.	DESTROYED A TIREA
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State how the City of Portland or its employees were at fault: IT WAS NOT ATIMELY FIXED d.

DRIVERS AT RISK OF INIVRY PUT MANNER AND Were you on the job at the time of the accident? Yes No X e. If yes, what is the name / phone number of employer _

H:\Projects\Web Pages\Liability Documents\2020 GENERAL LIABILITY CLAIM form

- 4. Description: Describe the injury, property damage or loss so far as is known at the time of this claim. <u>POPPED TIRE, SHREPDED IT. TIRES WERE LESS THAN 1 YEAR OLD.</u> COSMETIC DAMAGE TO RM, BROKE PLASTIC FROM UNDERSIDE OF CAR.
- 5. *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____ No ____
- 7. Name and address of any other person injured <u>NA</u>
- 8. Name and address of the owner of any damaged property if different from claimant N/A
- 9. Damages claimed:
 - a. Amount claimed as of this date: \$ 234.60
 - b. Estimated amount of future costs:
 - c. Total amount claimed:

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5	254-60	

NEW TIRE

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d. Basis for computation of amounts claimed (include copies of all bills, invoices, estimates, etc.):

).	Names, addresses / phone #s of all witnesses	
	SAM & CAITLYN ROBB WERE IN THE VEHICLE WITH THEIR ONE	e
	YEAR OLD SON.] PICKED THEM UP FROM THE AIRPORT, 622 NE FARE	0 5
	Any additional information that might be helpful in considering your claim PORTLAND, OR G	177

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: Claimant's Signature

HOMAS RENNETT Print Name

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