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AUTO LIABILITY
CLAIM AGAINST THE CITY OF PORTLAND

** for auto accidents involving a City vehicle **

File Number: 2025000981AL

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, email: LiabilityClaims@portlandoregon.gov

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

a. Address 447 GARDENHOME RD SW City PORTLAND State WA Zip 97219

b. Home Phone 971-337-8674 Business Telephone _____ Cell Phone _____

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

If married, name of spouse _____

d. E-mail address [redacted]

2. If claim involves a vehicle: a. Year, make and model 2024 SUBARU IMPREZA

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

c. At time of accident, were you (check all that apply): Owner X 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 _____

3. Insurance: a. What company insures the damaged vehicle? PROGRESSIVE

b. Policy Number [redacted] Claim Number: 25-247919347

c. Name and address of your insurance agent or adjuster SHIRLEY GAYMON 440.932.5176

_____ Type of Coverage _____

4. Occurrence or event from which the claim arises:

a. Date of incident 01/31/2025 b. Exact location SW GARDEN HOME & 45TH, PORTLAND, , 97219 PORTLAND, OR USA

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

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

d. Nature and extent of any injuries _____

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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 X

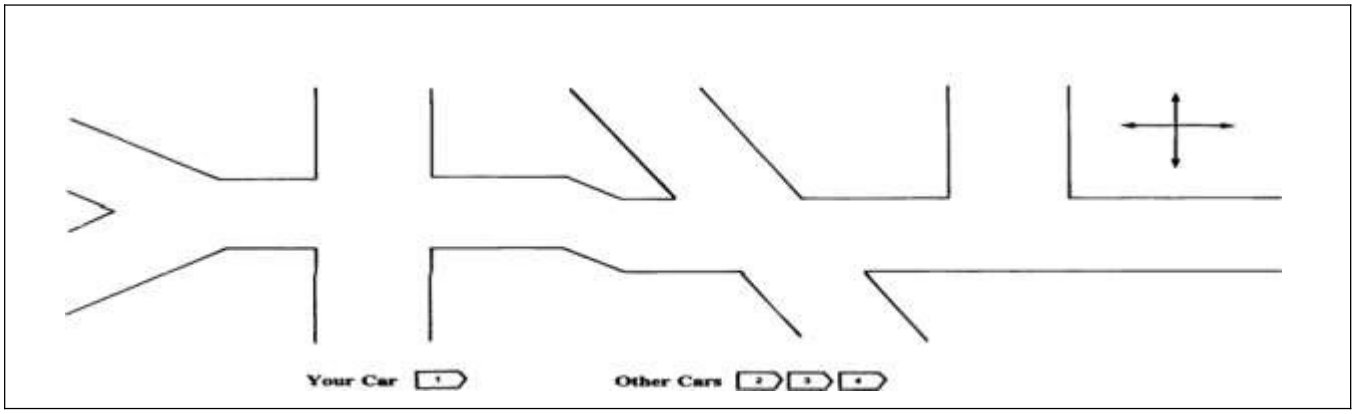
If yes, what is the name / phone / address of your employer? _____

_____

h. Name of City of Portland Driver MATTHEW SULLIVAN City vehicle license# UNK

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.

CITY OF PORTLAND CARGO VAN STRUCK PARKED PROGRESSIVE CUSTOMER

6. Damages claimed:

a. Amount claimed as of this date _____

b. Estimated amount of future costs _____

c. Total amount claimed _____

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.

07/02/2025

DATE

CLAIMANT'S SIGNATURE

City of Portland Risk Management 7/2/2025