



Post Office Box 878
Ephrata, Washington 98823
(509) 766-2505 www.grantpud.org

TORT CLAIM FORM FOR DAMAGES

If the claim submission is incomplete, Grant PUD may request additional information necessary to complete its review and evaluation of the claim.

PRESENT THE TORT CLAIM FORM AND SUPPORTING DOCUMENTS TO:

Submit by Email:

RiskDepartment@gcpud.org

OR

Mail original claim to:

Risk Department
Grant PUD
P.O. Box 878
Ephrata, WA 98823

OR

Deliver original claim to:

Risk Department
Grant PUD
30 C Street SW Ephrata,
WA 98823

Office Hours: Monday through Friday, from 9:00 am. to 4:00 pm. The office is closed on weekends and official holidays.

A claim shall be deemed presented when the Claim Form is personally delivered to, or is received by, the designated Agent for Grant PUD by email, regular mail, registered mail, or certified mail with return receipt requested.

LEGAL REQUIREMENTS FOR PRESENTING TORT CLAIM FORMS:

In order to verify the claim and supporting information, the law requires that the Tort Claim Form be signed by:

- Claimant, or the Claimant's parent or legal guardian if the Claimant is under 18 years of age; or
- Person holding a written power of attorney from the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- Court-approved guardian or guardian ad litem on behalf of the Claimant.

Pursuant to RCW 4.96, all tort claims against Grant PUD must be presented using the Tort Claim Form. Information submitted may be subject to disclosure under Washington's Public Records Act, Chapter 42.56 RCW, subject to applicable exemptions.

INSTRUCTIONS FOR COMPLETING A TORT CLAIM FORM:

Type or print clearly in ink and sign the Tort Claim form.

Provide all requested information and any available documentation supporting your claim, including but not limited to: medical records or bills for personal injuries, photographs, proof of ownership for property damage, receipts for property value, or other relevant evidence.

If additional space is needed to answer any question, attach separate sheets and clearly identify the corresponding section number.

If you are presenting a claim for personal injury, sign the AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION form.



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TORT CLAIM FORM

For Grant PUD Use Only

Pursuant to Chapter 4.96 RCW, tort claims against Grant PUD may be presented using either this Tort Claim Form or the Standard Tort Claim Form maintained by the Office of Risk Management within the Department of Enterprise Services. Information submitted may be subject to disclosure pursuant to Washington's Public Records Act, Chapter 42.56 RCW, subject to applicable exemptions.

A separate Tort Claim Form must be submitted for each Claimant.

SUBMIT COMPLETED CLAIMS TO:

<u>Email:</u>	<u>Mailing Address:</u>	<u>Physical Delivery Address:</u>
RiskDepartment@gcpud.org	Risk Department Grant PUD P.O. Box 878 Ephrata, WA 98823	Risk Department Grant PUD 30 C St. SW Ephrata, WA 98823

CLAIMANT INFORMATION

1. Claimant's full legal name (*Last, First, Middle*):

2. Date of birth (*mm/dd/yyyy*):

3. Current residential address:

4. Mailing address (if different):

5. Grant PUD account number and/or meter number affected (if applicable):

6. Claimant's daytime telephone number:

(Home) _____ (Work or Mobile) _____

7. Claimant's email address:

INCIDENT INFORMATION

8. Date of incident:

Time of incident

_____ a.m. ☐ p.m. ☐ (*check one*)

9. If the incident occurred over a period of time, date of first and last occurrences:

From: _____, Time: _____ a.m. ☐ p.m. ☐ To: _____ Time: _____ a.m. ☐ p.m. ☐
(*mm/dd/yyyy*) (*mm/dd/yyyy*)

10. Location of incident:

County: _____ City: _____ Specific Location of Occurrence _____

11. If the incident occurred on a street, highway, easement or right-of-way:

Name of street: _____ Street address or nearest milepost: _____ Nearest intersection: _____

INCIDENT INFORMATION**(continued)**

12. Names, addresses and telephone numbers of all persons involved in or witnesses to this incident:

13. Describe how Grant PUD caused your injuries or damages (if they were not caused by Grant PUD, you must file your claim with the correct entity):

14. List of damages:

Attach estimates, invoices, receipts, photographs, and other supporting documentation.

Item	Purchase Date	Purchase Price	Repair Cost	Was surge protection in use?
			Estimate ☐ Actual ☐	
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

15. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

16. (Complete only if claiming personal Injury) Provider name, addresses and telephone number and type of treatment. Attach copies of all medical reports and billings.

17. Have you submitted this loss to an insurance company? If yes, insurance carrier, claim number, adjuster name & telephone number:

18. Sum of damages claimed from Grant PUD: \$ _____

19. Are you represented by an attorney? ☐ No ☐ Yes If yes, Attorney name, law firm, address, & phone number:

CLAIMANT SIGNATURE

This Claim Form must be signed by the Claimant; the Claimant's parent or legal guardian if the Claimant is under 18 years of age; an individual holding a valid written power of attorney on behalf of the Claimant; an attorney admitted to practice law in the State of Washington and acting on behalf of the Claimant; or a court-appointed guardian or guardian ad litem acting on behalf of the Claimant. If the signer is not the Claimant, written proof of authority must be attached.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing information is true and correct.

Signature

Date

Printed name & relationship to Claimant (if applicable)



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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

CLAIMANT/PATIENT INFORMATION

1. Claimant/Patient Name (*Last, First, Middle*):

Date of Birth (*MM/DD/YYYY*):

I authorize any physician, hospital, clinic, pharmacy, counselor, psychologist, psychiatrist, therapist, health care provider, health care facility, health plan, governmental agency, insurer, employer, or other entity possessing health care information about me to disclose such information to: Public Utility District No. 2 of Grant County, Washington ("Grant PUD"), its attorneys, insurers, claims administrators, investigators, consultants, and authorized representatives.

This authorization is provided solely for the purpose of investigating, evaluating, administering, defending, resolving, or otherwise processing my tort claim for damages against Grant PUD.

Unless limited below, this authorization includes:

- ☐ Medical records
- ☐ Medical history
- ☐ Emergency room records
- ☐ Hospital records
- ☐ Physician records
- ☐ Urgent care records
- ☐ Diagnostic imaging and radiology records
- ☐ Laboratory and pathology reports
- ☐ Prescription and medication records
- ☐ Rehabilitation and therapy records
- ☐ Mental health treatment records
- ☐ Substance use disorder treatment records, to the extent permitted by applicable law
- ☐ Billing records related to diagnosis and treatment
- ☐ Other: _____

ACKNOWLEDGEMENTS

I understand my health information is protected by federal and state law, including HIPAA and applicable provisions of Chapter 70.02 RCW.

I understand information disclosed pursuant to this Authorization may no longer be protected by HIPAA after disclosure and may be subject to redisclosure as permitted by law.

I understand I may revoke this Authorization at any time by providing written notice to Grant PUD. Such revocation will not affect disclosures made before Grant PUD receives the revocation.

I understand signing this Authorization is voluntary; however, failure to provide information relevant to my claim may affect Grant PUD's ability to investigate or evaluate the claim.

I understand a photocopy, scanned copy, electronic copy, or facsimile of this Authorization shall be considered as valid as the original.

I understand that unless revoked sooner, this Authorization shall expire on the later of: One (1) year from the date signed below or the date my tort claim is fully resolved, closed, settled, withdrawn, or otherwise concluded.

CLAIMANT SIGNATURE

I declare under penalty of perjury under the laws of the State of Washington that the information provided in this Tort Claim Form and all attachments is true and correct to the best of my knowledge.

Signature

Date

Printed Name & Relationship to Claimant (if applicable)



VEHICLE COLLISION FORM

PLEASE TYPE OR PRINT IN INK

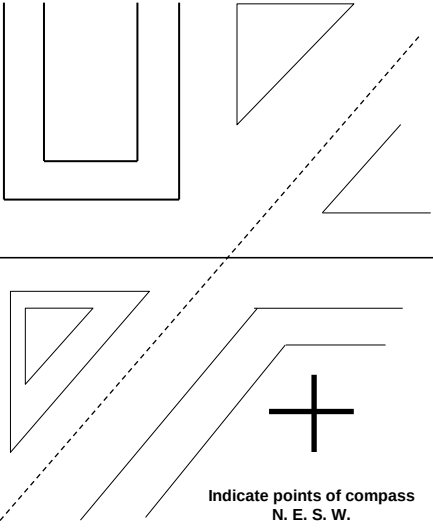
This form must be completed and attached to your tort claim form, if the claim involves a vehicle collision.

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT (mm/dd/yyyy)			TIME		AM	PM		
	CURRENT STREET (RESIDENCE) ADDRESS				CITY	STATE	ZIP	PHONE	WORK				
	(RESIDENCE) STREET ADDRESS FOR 6 MONTHS PRIOR TO THE ACCIDENT				CITY	STATE	ZIP	EMAIL					
	STATE/COUNTY/CITY (IF APPLICABLE) WHERE OCCURRED				STREET OR HWY		MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD					
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.		WHERE CAN CAR BE SEEN?			WHEN?				
	NAME OF VEHICLE OWNER			ADDRESS			CITY	HOME AND WORK PHONE					
	NAME OF DRIVER			ADDRESS			CITY	HOME AND WORK PHONE					
	DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE			DATE OF EXPIRATION						
	DESCRIBE DAMAGE				ESTIMATE \$		YOUR INSURANCE COMPANY AND POLICY NO.						
OTHER VEHICLE INFORMATION (VEHICLE #2)	YEAR	MAKE	MODEL	LICENSE PLATE NO.		CITY DIVISION, IF KNOWN							
	NAME OF DRIVER			ADDRESS			CITY	PHONE					
	NAME OF DRIVER			ADDRESS			CITY	PHONE					
	DESCRIBE DAMAGE						ESTIMATE \$						
OTHER (NON-VEHICLE) DAMAGE	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.												
	NAME OF OWNER			ADDRESS			CITY	PHONE					
	DESCRIBE DAMAGE							ESTIMATE \$					
INJURED PARTIES (# people in car, if known)	NAME		ADDRESS		PHONE		INJURY	AGE	VEH 1	VEH 2	VEH 3	PED	OTH
					HOME WORK								
					HOME WORK								
					HOME WORK								
					HOME WORK								
					HOME WORK								
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)				ADDRESS		CITY	PHONE					
								HOME WORK					
								HOME WORK					
								HOME WORK					

COMPLETE ALL DETAILS

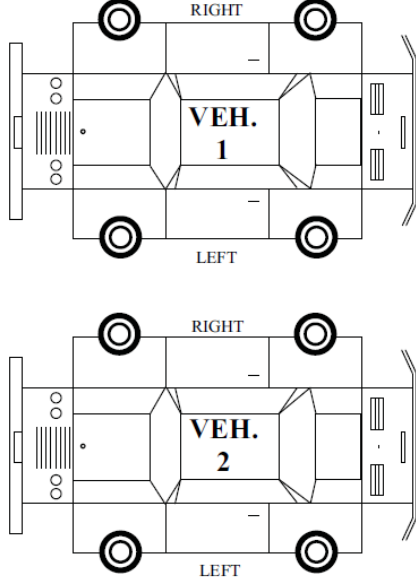
Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

☐ Straight Road ☐ Curve – R or L ☐ Level	☐ Hillcrest ☐ Uphill ☐ Downhill	☐ One Lane ☐ One and One-Half Lane ☐ Two Lane or Four Lane
Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.		
Sidewalk Street Center	Sidewalk IMPORTANT If street or view was obstructed In any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.	



Indicate points of compass
N. E. S. W.

Mark Damaged Areas



LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL	TYPE OF ROAD (CHECK ONE OR MORE)	VEHICLE CONDITION (CHECK ONE OR MORE)	ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)
1 ☐ DAYLIGHT	VEHICLE NO. 1 NO. 2 ☐ 1 ☐ SIGNALS	VEHICLE NO. 1 NO. 2 ☐ 1 ☐ ONE WAY	VEHICLE NO. 1 NO. 2 ☐ 1 ☐ DEFECTIVE BRAKES	VEHICLE NO. 1 NO. 2 ☐ 1 ☐ DRY	1 ☐ CLEAR, CLOUDY & OVERCAST
2 ☐ DAWN	☐ 2 ☐ STOP SIGN	☐ 2 ☐ TWO WAY	☐ 2 ☐ DEFECTIVE HEADLIGHTS	☐ 2 ☐ WET	2 ☐ RAINING
3 ☐ DUSK	☐ 3 ☐ FLASHING RED	☐ 3 ☐ REVERSIBLE ROAD	☐ 3 ☐ DEFECTIVE REAR LIGHTS	☐ 3 ☐ SNOW	3 ☐ SNOWING
4 ☐ DARK - STREET LIGHTS ON	☐ 4 ☐ FLASHING AMBER	☐ 4 ☐ INTERCHANGE LOOP RAMP	☐ 4 ☐ TIRES WORN	☐ 4 ☐ ICE	4 ☐ FOG
5 ☐ DARK - STREET LIGHTS OFF	☐ 5 ☐ RR SIGNAL	☐ 5 ☐ ALLEY	☐ 5 ☐ PUNCTURED OR BLOWN TIRES	☐ 5 ☐ OTHER (SPECIFY)	5 ☐ OTHER (SPECIFY)
6 ☐ DARK - NO STREET LIGHT	☐ 6 ☐ OFFICER/ FLAGMAN	☐ 6 ☐ TWO WAY - LEFT TURN LANES	☐ 6 ☐ OTHER (SPECIFY)	NAME OF INVESTIGATING POLICE AGENCY: INVESTIGATING AGENCY REPORT NO.	
☐ OTHER (SPECIFY)	☐ 7 ☐ YIELD SIGN	☐ 1 ☐ SEPARATED			
	☐ 8 ☐ NO TRAFFIC CONTROL	☐ 2 ☐ DIVIDED			
	☐ 9 ☐ OTHER	☐ 3 ☐ UNDIVIDED			

A separate claim form should be submitted for each claimant.

This information is being provided to aid in resolving a claim.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant

Date and Place (residential address, city and county)