Boston Water and Sewer Commission

980 Harrison Avenue
Boston, MA 02119
617-989-7000
www.bwsc.org

BOSTON WATER AND SEWER COMMISSION
STANDARD CLAIM FORM

Submission of this form does not constitute notice to the Executive Director of the Boston Water and Sewer Commission for purposes of M.G.L. Chapter 258, the Massachusetts Tort Claims Act. The information requested on this form may be subject to public disclosure.

To file this form please email it to claims@bwsc.org or mail or deliver the original claim for to:

Legal Department
Boston Water and Sewer Commission
980 Harrison Avenue
Boston, MA 02119

You may also fax this form to: (617) 989-7736

If you email this form, please do not include or attach any personally identifying information such as social security numbers, medical files, health care policy numbers or other similar information.

CLAIMANT INFORMATION:

Name:_____

Home address: _____

Mailing address (if different):_____

Telephone number _____ _____
Home Business or Cell

E-mail address:
_____

INCIDENT INFORMATION:

Date of the incident: _____ Time: _____

Location of Incident: _____

Description of incident: (Attach additional sheets if necessary)

_____

_____

_____

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Description of property damage:

Description of personal Injuries:

Hospitals:

1. Name:_____

   Address:_____

   Dates:_____

2. Name:_____

   Address:_____

   Dates:_____

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Doctors/Chiropractors/Physical Therapists:

1. Name:_____

   Address:_____

   _____

   Dates of Treatment:_____

2. Name:_____

   Address:_____

   _____

   Dates of Treatment:_____

WITNESSES:

Witnesses to Incident (attach additional sheets if necessary)::

1. Name:_____

   Address:_____

   _____

   Telephone:_____

2. Name:_____

   Address:_____

   _____

   Telephone:_____

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STATEMENTS:

Statements made to Insurance Companies, Law Enforcement, etc.:

Date made:_____

Name/Address/Title of Person taking statement:

_____

_____

_____

Please provide a copy of any written statements.

DAMAGES / LOSS:

Lost wages:_____

Medical expenses:_____

Personal injury:_____

Property damage:_____

The total amount of damages claimed. (This should include your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation sought) _____

Please attach any additional documents that support your claim including but not limited to photographs, appraisals, estimates, medical bills or receipts of any kind relating to the claimed loss.

This claim form must be signed by the Claimant.

_____

Signature of Claimant

_____

Date

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PLEASE NOTE: IF YOU FILE A CLAIM FOR PERSON INJURY, YOU WILL BE ASKED TO FILL OUT A MEDICARE, MEDICAID AND SCHIPP EXTENSION ACT (MMSEA) REPORTING COMPLIANCE DECLARATION