

**BOSTON WATER AND SEWER COMMISSION
STANDARD CLAIM FORM**

All claims for personal or property damages from a defect in the public way must be filed within **thirty (30) days** of the date of the incident per the Statute of Limitations, Massachusetts General Laws Chapter 84 § 18. 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 form 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 incident: _____ Time of incident: _____

Location of incident: _____

Description of incident (attach additional sheets if necessary):

Description of property damage:

Description of personal injuries:

Hospitals:

1. Name: _____

Address: _____

Dates: _____

2. Name: _____

Address: _____

Dates: _____

3. Name: _____

Address: _____

Dates: _____

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: _____

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):



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

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

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