University of Kentucky Claim Form (ONLY FOR CLAIMS LESS THAN \$250.00)

University of Kentucky Office of Legal Counsel 301 Main Building Lexington, KY 40506-0032 (859)323-7237 www.uky.edu/legal

Please provide all the facts, statements by witnesses (in writing), or any other proof you have that you believe would be helpful in the determination of your loss/claim. The burden of proof that the University was negligent rests with you. FOR THE CONSIDERATION OF CLAIMS OVER \$50, YOU MUST PROVIDE A PROOF OF PURCHASE OR A RECEIPT. IF THE CLAIM AMOUNT IS MORE THAN \$250, YOU MUST FILE WITH THE KENTUCKY BOARD OF CLAIMS.

Please complete <u>ALL</u> sections of this form and submit via email by clicking the submit button at the end of the form or print and return by mail to the below address or scan to boc250@uky.edu:

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ENTER DOLLAR AMOUNT OF CLAIM (YOU MUST ENTER AN AMOUNT)

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CITY, STATE, AND ZIP CODE		
EMAIL (<u>WE MUST HAVE AN EMAIL</u>)	PHONE NUMBER	
NAME OF UNIVERSITY OF KY EMPLOYEE INVOLVED IN THE INCIDENT	DATE INCIDENT OCCURRED (MUST BE WITHIN ONE YEAR)	TIME INCIDENT OCCURED
WHERE DID THE INCIDENT OCCUR? (GIVE EXACT LOCATION THAT APPLIES INCLUDING CITY, COUNTY, DIRECT	CTION, BUILDING, ROOM NUMBER, MILE MARKER, INTERSECTION	ON, ETC. <u>PLEASE BE SPECIFIC</u>
BELOW DESCRIBE THE INCIDENT AND THE DAMAGE DONE TO YOU OR YOUR PROPERTY:		
BELOW DESCRIBE HOW YOU FEEL THE UNIVERSTIY OF KENTUCKY IS AT FAULT:		
PLEASE PROVIDE THE SPECIFIC DOLLAR AMOUNT OF YOUR CLAIM. Supply bills Pursuant to KRS 49.130 Conditions of awards - Reduction of award this amount sources available to the claimant, such as worker's comp, social security, federal claimant's expenses or damages incurred.	will be amended according to the amount tha	t can be recovered from othe
IF YOUR CLAIM IS OVER \$250.00 STOP HERE YOU MUST FILE WITH THE KENTUC TO THE STATE IF IT IS OVER \$250.00)	KY BOARD OF CLAIMS, (BE ADVISED YOUR CLA	IM WILL NOT BE FORWARE

THE PAGE(you must provide your signature, 4 digits of your social, date of claim form and email before submitting the form. If motor vehicles were involved, please complete the following information: STATE'S VEHICLE: STATE VEHICLE TAG NUMBER, if known FULL NAME OF DRIVER OF STATE VEHICLE, if known DOES THE OPERATOR OF THE STATE OWNED VEHICLE HAVE A RIDER ON THIER INSURANCE POLICY TO COVER THEM WHILE OPERATING A STATE OWNED VEHICLE, IF SO THE CLAIMANT MUST GO THROUGH THE STATE EMPLOYEE'S INSURANCE. STATE EMPLOYEE'S PERSONAL INSURANCE RIDER **CLAIMANT'S VEHICLE** THIS CLAIM MUST BE FILED AND SIGNED BY THE REGISTERD OWNER OF THE VEHICLE FULL NAME OF THE REGISTERED OWNER OF THE CLAIMANT'S VEHICLE INVOLVED IN THE INCIDENT **VEHICLE INFORMATION:** YEAR, MAKE, AND MODEL OF THE CLAIMANT'S VEHICLE CLAIMANT/DRIVER AND PASSENGER INFORMATION: CLAIMANT/DRIVER FULL NAME (FIRST AND LAST NAME) CLAIMANT/DRIVER STREET ADDRESS (INCLUDE APT# OR UNIT#) CLAIMANT/DRIVER CITY, STATE, AND ZIP CODE PASSENGER FULL NAME (FIRST AND LAST NAME) PASSENGER STREET ADDRESS (INCLUDE APT# OR UNIT#) PASSENGER CITY, STATE, AND ZIP CODE POLICE OR INCIDENT REPORT: IF POSSIBLE PLEASE SUBMIT A COPY OF THE POLICE REPORT, INCIDENT REPORT OR UNIFORM TRAFFIC REPORT NAME OF LAW ENFORCEMENT OFFICER WHO INVESTIGATED THE INCIDENT THIS FORM MUST BE SIGNED: **CLAIMAINT'S SIGNATURE (REQUIRED)** By typing your name in the above box you certify that to the best of your knowledge the provided information is true and accurate. SIGNATURE OF RESPONSIBLE PARTY ONLY IF CLAIMANT IS A MINOR By typing your name in the above box you certify that to the best of your knowledge the provided information is true and accurate. WE MUST HAVE: LAST 4 DIGITS OF CLAIMANT'S SOCIAL SECURITY NUMBER PHONE NUMBER WE MUST HAVE AN EMAIL STREET ADDRESS CITY, STATE, ZIP CODE YOU MUST PROVIDE THE DATE: DATE FORM COMPLETED (MM/DD/YYYY) CLICK HERE TO SUBMIT

If the claim involves a motor vehicle please proceed to the next field, if not you may skip to the signature field AT THE BOTTOM OF