

**NOTICE OF TORT CLAIM**

In order to submit your claim, you must complete this form and submit it to the Mayor of the Municipality within **NINETY (90)** days of the occurrence. The Municipality will then forward your claim to the New Mexico Self-Insurers' Fund for investigation and adjustment. You may expect to be contacted by a Fund representative regarding your claim. Please call (800) 432-2036 or (505)982-5573 if you have questions.

To Municipality of \_\_\_\_\_

Claimant: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ \* SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ \*

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Date of Occurrence: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Occurrence: \_\_\_\_\_ AM or PM (Circle One)

Location of Occurrence: \_\_\_\_\_

Please describe what happened: (continue on blank sheet if necessary) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness Name: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Witness Name: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Please list all persons and/or property for which you are claiming damages:

1. \_\_\_\_\_ \$ \_\_\_\_\_

2. \_\_\_\_\_ \$ \_\_\_\_\_

3. \_\_\_\_\_ \$ \_\_\_\_\_

4. \_\_\_\_\_ \$ \_\_\_\_\_

TOTAL AMOUNT OF CLAIM \$ \_\_\_\_\_

Please attach all estimates, bills, or other information to support the amount of your claim.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**\*This information is required by the federal government. No payment can be made without this information.**

THIS SIDE FOR MUNICIPAL OFFICIAL USE ONLY.

Notice of Tort Received By \_\_\_\_\_  
Name Title

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM/PM (Circle One)

Persons having knowledge of the circumstances surrounding this claim:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Attached are the following reports, statements or other documentation which support our understanding of the facts relating to this claim:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please describe any other information which you feel is pertinent to this claim: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Submitted by: \_\_\_\_\_  
Signature Print Name

Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Upon receipt of this claim, please provide the above information and *immediately* send to:

New Mexico Self-Insurers' Fund  
P.O. Box 846  
Santa Fe, NM 87504  
(800) 432-2036 or (505) 982-5573  
Fax (505) 820-0670