How to File a Tort Liability Claim

If you believe you have suffered a loss that William Paterson University is responsible for, you must file a tort liability claim (see instructions below). All claims are filed with and processed by the State of New Jersey.

Contact Business Services for assistance with your claim if needed (Donna McNerney at 973-720-2107). In-person assistance is available at College Hall by appointment; please call 973-720-2107 to make an appointment.

You will mail your completed form with attachments to the State of New Jersey. You must provide a copy to WPU Business Services as well.

Note that you must file the form within 90 days of the date of loss. The state does not have a stated time frame for resolution of claims – times vary and can be lengthy. To minimize the turnaround time, be sure that the information and documentation you provide with your tort liability claim form is as thorough as possible. The claim will be resolved faster if all information is provided up front and the state does not need to come back to us looking for further information or documentation.

Instructions:

1. Complete the attached form entitled Claim For Damages Against State of New Jersey.
2. Be sure to read and follow the instructions for the form, including those relating to attachments and the deadline for filing.
3. If you have a police report relating to your claim, include that as an additional attachment.
4. Provide a copy of the completed form and attachments to Business Services, attention Donna McNerny, at:
   - Email: mcnerneyd@wpunj.edu
   - In person or by mail: Business Services, College Hall room 326, 358 Hamburg Turnpike, Wayne, NJ 07470
5. Mail the form to the NJ Department of Treasury address indicated on the form instructions. The form must be filed within 90 days of the incident.

Notice of Claim Instructions

If you wish to make a claim against the State of New Jersey, please read the following information:

The State of New Jersey is protected from Tort actions by State Statue Title 59, and more specifically, Chapter 9, Paragraph 2e. Simply stated, Title 59: 9-2e means that, if you have insurance to cover "physical damage" to your property, the money you are entitled to receive under such policy of insurance shall be deducted from your claim against the State.

To expedite settlement of your claim, we ask that you settle your physical damage with your physical damage insurance carrier.

You may submit a claim for your deductible by forwarding a copy of your estimate and a copy of the declaration sheet showing the amount of your physical damage deductible to the address listed below.

If you do not have "physical damage" coverage and wish to submit a claim, please forward an estimate for the damage, a copy of the declaration sheet on your insurance policy, and complete the enclosed Tort claim form.

Since all claims which are filed against the State of New Jersey must be filed within 90 days of their occurrence, we suggest that your documentation be sent via certified mail. Although this is not required, it will insure that you have proof of receipt by this office.

Should our investigation reveal that the State is liable for your damage, you will be compensated.

Please allow a minimum of 90 days for a reply to your claim submittals.

Mail your response to:

Dept. of Treasury
Bureau of Risk Management
P.O. Box 620
Trenton, NJ 08625
Attn.: Tort Claims Unit

FOR OFFICE USE ONLY:

CLAIM FOR DAMAGES AGAINST STATE OF NEW JERSEY

Forward to: Bureau of Risk Management
Tort & Contract Unit
P.O. Box 620
One West State Street
Trenton, New Jersey 08625

1. Claimant:

Last Name, First Middle — Date of Birth

Street Address — Mailing address if other than Street address

City State Zip Code — Social Security Number

If notices and correspondence in connection with this claim are to be sent to a person other than claimant, complete Item #2.

2. Name — Mailing Address

City State Zip Code

Relationship to claimant: Attorney at Law [ ] or — Explain Relationship

The occurrence or accident which gave rise to this claim:

3a. Date — Time

b. Describe the location or place of the accident or occurrence.

Municipality — Exact location of the occurrence

c. Describe how the accident or occurrence happened: If a diagram will assist your explanation, please use the reverse side of this form.

d. State the name and address of the State agency or agencies that you claim caused your damage.

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e. State the names of State employees whom you claim were at fault, including any information that will assist in identifying and locating them.

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f. State the negligence or wrongful acts of the State agency and State employees which caused your damages.

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g. State the name and address of all witnesses to the accident or occurrence.

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h. State the names of all police officers and police departments who investigated the accident.

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4a. Claim for Damages (check appropriate block)

[ ] Personal Injury [ ] Property Damages

[ ] Other – Explain in detail ____

b. If you claim personal injury:

(1) Describe your injuries resulting from this accident or occurrence

(2) Do you claim permanent disability resulting from this injury:
[ ] Yes [ ] No

If yes, describe the injuries believed to be permanent.

(3) For each hospital, doctor or other practitioner rendering treatment, examination or diagnostic services, state:

Name of hospital, doctor or other facility	Address	Dates if treatment or service	Amount of charges to date	Amount paid or payable by other sources such as insurance.

(4) If you claim loss of wages or income as a result of the injury, state:

Name of employer	Address of employer
Your occupation	Date you became employed
Rate of pay	Dates of absence from work
Total lost wages to date	If still out, expected date of return

NOTE: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.

I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, that I am subject to punishment provided by law.

Dated:______________________________ ______________________________

Claimant or person filing claim on behalf of claimant.

To Whom It May Concern:

I hereby authorize any and all doctors, hospitals or other medical service facilities to release to the Sate of New Jersey any and all records, reports and other information concerning the treatment of the claimant named herein.

Dated:______________________________ ______________________________

(Signature)

(This must be signed by the claimant or the parents of claimants who are minors)