



Dear Claimant:

Enclosed is a form which, should you choose to file a claim, must be returned to our office filled out in its entirety before it can be submitted to the Santa Cruz Metropolitan Transit District's (METRO) Board of Directors for their consideration. Providing you with this information and form should not be construed as an admission of liability by the District.

Please be advised that METRO investigates each claim fully. If it is determined that neither the Bus Operator nor METRO caused or contributed to the incident which resulted in your personal injury and/or property damage, your claim will be sent to the Board with a recommendation that the claim be rejected.

As required by Government Code Section 911.2, a claim must be filed with the METRO within six months of the incident. Please use additional paper if needed.

Completed claims must be mailed or hand delivered (no faxes will be accepted) to:

**Santa Cruz Metropolitan Transit District  
Attn: Secretary to the Board of Directors  
110 Vernon Street  
Santa Cruz, CA 95060**

Please be advised that if the property damage is between \$500.00 and \$5,000.00, a minimum of two repair estimates will be required. If applicable, please also provide a copy of the vehicle's current registration or other proof of vehicle ownership. If you have any questions or concerns, please feel free to contact METRO's Claims Investigator at 426-6080, ext. 1603.

**WARNING: It is a criminal offense to file a false claim (Penal Code Section 72).**



**Santa Cruz Metropolitan Transit District**

110 Vernon Street  
Santa Cruz, CA 95060

**CLAIM FOR DAMAGES**

(Pursuant to Section 910 et Seq., Government Code)

Claim # \_\_\_\_\_  
(To be completed by METRO staff)

Please Print or Type:

The name and post office address of the claimant:

Claimant's Legal First Name: \_\_\_\_\_

Claimant's Legal Last Name: \_\_\_\_\_

Address to which notices are to be sent: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_

Telephone (Business/Cell): \_\_\_\_\_

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that the Santa Cruz Metropolitan Transit District report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist Centers for Medicare and Medicaid Services and other insurance plans to properly coordinate payment of benefits among plans so that (your) claims are paid promptly and correctly. We are asking you to answer the following questions so that we may comply with this law.

Are you presently, or have you ever been, enrolled in Medicare Part A or B? Yes  or No

**IF YES**, please provide the following information:

Medicare Claim Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_



Gender: M  or F

Claimant Name: \_\_\_\_\_

### CLAIM FOR DAMAGES

The date, place and other circumstances of the occurrence or transaction that gave rise to the claim asserted:

Date of Incident/Accident: \_\_\_\_\_

Time of Incident/Accident: \_\_\_\_\_  AM  PM

Location of Incident/Accident

Street/City: \_\_\_\_\_

A general description of the indebtedness, obligation, injury, damage or loss incurred so far as it may be known at the at the time of presentation of the claim. Please state the known facts surrounding the loss and use additional paper if needed.



Claimant Name: \_\_\_\_\_

### CLAIM FOR DAMAGES

The name or names of the METRO employee or employees causing the injury, damage, or loss, if known:

If the claim totals less than \$10,000, the amount claimed as of the date of the presentation of the claim: \_\_\_\_\_

If the amount exceeds \$10,000, this claim would be:  Less than \$25,000 (Limited Civil Case)       More than \$25,000

Claimant: \_\_\_\_\_  
Signature/Print Name

Date: \_\_\_\_\_

Attorney or Representative: \_\_\_\_\_  
Signature/Print Name

Date: \_\_\_\_\_