

STATE OF FLORIDA DEPARTMENT OF TRANSPORTATION
STATEMENT OF CLAIM FOR PROPERTY DAMAGE

225-085-01
GENERAL COUNSEL
04/04/12

Office of the General Counsel, Department of Transportation, 605 Suwannee Street, MS 58, Tallahassee, FL 32399-0458
dotclaims.review@dot.state.fl.us

FILE NO. _____
(do not complete)

NAME: _____ ADDRESS: _____	
CITY AND STATE: _____ E-MAIL (Optional): _____	
PHONE NO.: (Home) _____ (Work) _____ (Cell) _____	
DATE OF INCIDENT : _____ TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
LOCATION OF INCIDENT : (e.g., Mile Marker, Cross Streets, Exit Number) _____	
CITY AND COUNTY WHERE INCIDENT OCCURRED: _____	
MAKE, MODEL, AND YEAR OF VEHICLE, IF APPLICABLE: _____	
LICENSE PLATE NUMBER: _____	
VEHICLE OWNER'S NAME AND ADDRESS: _____ _____	
DRIVER'S NAME AND ADDRESS, IF APPLICABLE: _____ _____	
DESCRIBE THE DAMAGE TO YOUR PROPERTY AND HOW IT OCCURRED: _____ _____ _____ _____	
WHAT COMPANY CARRIES YOUR AUTO INSURANCE? _____	
HAVE YOU FILED A CLAIM WITH YOUR INSURANCE COMPANY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, PLEASE PROVIDE THE CLAIM NUMBER: _____	
DID YOU REPORT THIS INCIDENT TO LAW ENFORCEMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
IF YES, NAME THE AGENCY REPORTED TO: _____	
IF YOU HAVE A COPY OF THE REPORT, PLEASE PROVIDE _____	

UNDER SECTION 817.234, FLORIDA STATUTES, WHICH APPLIES TO THIS CLAIM, ANY PERSON WHO FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER IS GUILTY OF A FELONY.

DATE

SIGNATURE OF PERSON FILING CLAIM