SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT
Insurance Division
800 Madison Street
Oakland, CA 94604-2688

CLAIM AGAINST SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS 910 ET SEQ*

*Promptly complete this form and mail to: BART, 800 Madison Street, Oakland, CA 94604-2688, Attn.: Insurance Division

PLEASE PRINT:

NAME OF CLAIMANT: LAST NAME _____ FIRST NAME _____ INIT. ____

MAILING ADDRESS: STREET _____ CITY _____ STATE ____ ZIP CODE PLUS ____

TELEPHONE NO.: HOME ___ — ___ — ____ BUSINESS ___ — ___ — ____

DATE OF INCIDENT/OCCURRENCE: MONTH ___ DAY ___ YEAR ____ TIME ___ : ___ A.M. ☐ P.M. ☐

LOCATION/PLACE OF INCIDENT/OCCURRENCE:

(Please be specific, i.e., station, train, escalator, stairway, etc.) _____

DESCRIPTION OF OCCURRENCE OR INCIDENT: _____

NATURE OF INJURY, LOSS OR DAMAGE RESULTING FROM THE ABOVE: _____

CAUSE OF INJURY, OR DAMAGE (State what you believe caused the injury, loss or damage and state the name or names of the public employee or employees causing such injury, loss or damage if known): _____

AMOUNT CLAIMED AS OF DATE OF PRESENTATION OF CLAIM AND THE ESTIMATED AMOUNT OF FUTURE CLAIM, IF KNOWN: (include the basis of computation of the amount claimed): _____

I understand that, by furnishing this form, BARTD is not acknowledging any responsibility for payment of my claim.

(DO NOT DETACH — ALL (3) COPIES ARE TO BE RETURNED TO BART.)

Dated: _____ Signed: _____

***CLAIM MUST BE PRESENTED WITHIN 6 MONTHS OF INCIDENT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS.**