



Risk Management

Phone: 910.253.2078 / Fax: 910.253.2022

Email: risk@brunswickcountync.gov

Location: David R. Sandifer Administration Building
30 Government Center Drive NE, Bolivia, NC 28422

CITIZEN REQUEST TO FILE A CLAIM

This form is to be completed by the citizen filing a claim for damages or reimbursement from the County of Brunswick. Please complete all applicable information and be as specific as possible. Attach any documentation available (i.e. Police Report, invoices, bills, estimates, photographs, etc.). If estimates are attached, two (2) independent estimates for repair / replacement must be provided. This information will be provided to the County's insurance adjusting firm for investigation and disposition of the claim.

NOTE: BY SUBMITTING THIS FORM, THE COUNTY OF BRUNSWICK IS NEITHER ACCEPTING NOR DENYING LIABILITY OR RESPONSIBILITY FOR THE OCCURANCE DESCRIBED BELOW. AN INVESTIGATION WILL BE CONDUCTED BY THE COUNTY OF BRUNSWICK. FURTHER INFORMATION AY BE REQUIRED FROM THE CLAIMANT. THE CLAIMANT WILL BE NOTIFIED BY MAIL AS TO THE FINAL DISPOSITION OF THE CLAIM BY THE COUNTY'S INSURANCE ADJUSTING FIRM.

Occurrence Information:

Date of Occurrence: ___ / ___ / _____

Time of Occurrence: ___ : ___ a.m. / p.m.

Location of Occurrence: _____

Description of Occurrence: _____

Claimant Information:

Physical Address: _____

Mailing Address: _____

Phone Number: _____

Email Address: _____

Extend of Damages: _____

Estimate of Damages: \$ _____ **(Attach Documentation)**

Insurance Company: _____

Policy Number: _____

Insurance Agent: _____

Mailing Address: _____

Phone Number: _____

Email Address: _____

Witness: _____

Address: _____

Phone Number: _____

Email Address: _____

Witness Signature: _____

Witness: _____

Address: _____

Phone: _____

Email Address: _____

Witness Signature: _____

The above two (2) pages are true, complete, and accurate statements of the facts of my claim. I authorize the County of Brunswick to investigate my claim and to detain information, including confidential or medical information, that may be relevant to my claim.

Signature of Claimant

Date