INDIANA STATE FAIR TORT CLAIM FORM

Physical Injury or Death from Incident on August 13, 2011

OAG Form: 795549/Rev. 2011-09

RETURN COMPLETED FORM *by mail to:*
STATE FAIR TORT CLAIM ADMINISTRATOR
C/O JWF Specialty
Attn: Heather Hunter
600 E. 96th Street, Suite 425
Indianapolis, IN 46240

INSTRUCTIONS:

1. **Deadline for Submission of this form is Tuesday, November 1, 2011.**
2. To assist us in responding to your claim as soon as possible, please help us by completing the information requested in the form below.
3. If you need assistance in completing this form, please call 1-800-760-4616 or email:
   - Heather Hunter – heather.hunter@oldnationalins.com, or
   - Eileen Carroll – eileen.carroll@oldnationalins.com
4. Sign, date and return this form to the address in the upper right corner above.

NOTES:

- **Use this form to make a claim to the Tort Claim Fund under IC 34-13-3**
- **To apply for gift distributions from the Indiana State Relief Fund contact the Indiana State Fair Commission.**
- **All information provided in Sections 1 through 4 is subject to Public Access under the Indiana Access to Public Records Act, Indiana Code 5-14-3.**

SECTION 1: Claimant Information

Are you filing this claim on behalf of yourself?

☐ **Yes** Complete Section 1, and skip to Section 3 ☐ **No** Complete all sections and state your relationship to the injured person or decedent

Relationship to Injured Person or Decedent

Last Name	First Name	MI

Address	City	State	Zip

Phone Number (Day)	Phone Number (Evening)	Phone Number (Cell)	Email Address:

SECTION 2: Information for Non-Claimant Injured Person or Decedent (if filing a claim for yourself, skip to Section 3)

Last Name	First Name	MI

Address	City	State	Zip

SECTION 3: Additional Information Regarding the Claimant, Injured Person or Decedent

Hospital(s) and/or Medical Provider(s) *Please attach supporting documentation if available.*

Was Claimant, Injured Person or Decedent hospitalized and/or received any medical treatment? ☐ No ☐ Yes ☐ Still Hospitalized

If **Yes**, in the area below please state the hospital/facility name and total days admitted.

If **Still Hospitalized** please enter "SH" in the "Days" column.

Hospital(s) and/or Medical Provider(s)	Days

Did death occur as a result of the incident?, If **Yes**, please enter the date of death	☐ No ☐ Yes	Date (*m/d/yyyy*)

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SECTION 3: Additional Information Regarding the Claimant, Injured Person or Decedent -- *Continued*

Date of Birth (*m/d/yyyy*)

Occupation:

Income Range:
- ☐ Under $50,000
- ☐ $51,000–$75,000
- ☐ $76,000–$100,000
- ☐ 101,000 and Over

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced

Head of Household
- ☐ Yes
- ☐ No

Number of Dependents:

Dependent Name	Age

Education
- ☐ Some High School
- ☐ High School Graduate
- ☐ Some College
- ☐ College Graduate

Degrees Earned:

_____

_____

_____

Please enter a brief description of the job duties of the occupation:

Did the Injured Person miss work? If **Yes**, please enter the number of work days missed and employer name and address

Missed Work? ☐ No ☐ Yes ☐ Still not back to work

Days Missed _____

Employer Name _____

Employer Address _____

Please provide a brief description of the nature and extent of the injuries and the impact these injuries have had or are reasonably expected to have.

SECTION 4: Signature

I hereby certify that the information provided in this claim form application is true and accurate to the best of my knowledge and I am authorized to file this claim. I also authorize the State of Indiana to use information contained in this form for purposes of State Form 53788 (Information necessary to distribute payments from the state).

Claimant Printed Name	*Claimant Signature*	*Date (m/d/yyyy)*

Claimant Name: _____

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SECTION 5: Payment – Choose preferred method of payment

Materials provided in response to the request to provide patient medical records and financial records will be maintained confidentially and are not accessible by the public through the Access to Public Records Act based on the provisions of Indiana Code § 5-14-3-4(a)(1),(5),(9),(12), and/or other applicable authorities.

SECTION 5-A: Electronic Fund Transfer Option

Upon verification of claimed loss, a payment may be made based on established protocol from the Indiana Tort Claim Fund. Please provide information below for the administrator to determine payment dispersal as warranted.

Account Number	Routing Number	Social Security Number	Account Type: ☐ Checking ☐ Money Market ☐ Savings ☐ Other

Financial Institution	Name of Bank Contact if Known (*Optional*)

Address	City	State	Zip

Telephone Number Main	Fax Number	Other Telephone

SECTION 5-B: Waiver from Electronic Transfer Requirements Option

☐ I request a waiver from electronic transfer requirements. Please mail check made payable to:

Name: _____ Social Security Number: _____

Address: _____

City, State, Zip: _____

☐ Claimant

☐ Parent, Guardian or Representative

Claimant Name: _____