



INDIANA STATE FAIR TORT CLAIM FORM
Physical Injury or Death from Incident on August 13, 2011

OAG Form: 795549v2/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 (Injured Person or Decedent)				
Are you filing this claim on behalf of yourself?				
<input type="checkbox"/> Yes Complete Section 1, and skip to Section 3		<input type="checkbox"/> No Complete all sections		
Last Name		First Name		MI
Address			City	State Zip
Phone Number (Day)	Phone Number (Evening)	Phone Number (Cell)	Email Address:	

SECTION 2: Information for Claimant's Representative (if filing a claim for yourself, skip to Section 3)					
Last Name		First Name		MI	Relationship to Injured Person or Decedent
Address			City	State	Zip
Phone Number (Day)	Phone Number (Evening)	Phone Number (Cell)	Email Address:		

SECTION 3: Additional Information Regarding the Claimant												
Hospital(s) and/or Medical Provider(s)		<i>Please attach supporting documentation if available.</i>										
Was Claimant hospitalized and/or received any medical treatment?		<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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.												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;">Hospital(s) and/or Medical Provider(s)</th> <th style="width: 20%;">Days</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Hospital(s) and/or Medical Provider(s)	Days									
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		<input type="checkbox"/> No <input type="checkbox"/> Yes Date:										

