

CLAIM FOR DAMAGES



FREQUENTLY ASKED QUESTIONS

We understand you have sustained a loss and believe Franklin PUD may be responsible. If we prove to be responsible, we want to promptly and fairly compensate you. To evaluate your claim, we must determine how the incident happened, what the root cause of the incident was, and the extent of damages to customer property.

What is the claim process?

Franklin PUD, together with its insurance company (Federated), responds promptly and fairly to claims for damages. Each claim is evaluated on a case-by-case basis and is based on the information provided by the claimant, and results obtained from the incident investigation. The length of time for the investigation depends on the information provided by the claimant and the complexity of the incident. We strive to resolve claims in less than six weeks from the date the claim is received. Complex issues surrounding the claim will require more time.

Who is responsible?

Franklin PUD is responsible for damages that result from our negligence; however, we are not responsible for damages that we do not cause, or that are the result of forces beyond our control. For example, in most instances, we are not responsible for power outages or voltage fluctuations caused by weather related events or acts of nature (lightning, floods, earthquakes, or winds), customer-owned equipment failures, curtailments or outages initiated by the direction of any electric grid operator, or damages caused by 3rd parties. There may be situations in which Franklin PUD is only partially responsible for a loss, in which case a fair partial payment would be offered.

What do you need to provide?

Keep copies of all receipts so you can provide full and accurate documentation of your losses and damages. Read the Claim for Damages Form Packet. Follow the instructions and thoroughly complete the Claim for Damages Form. Submit the completed claim form, along with appropriate photographs, receipts and supporting documentation.

- For a personal injury claim, be prepared to approve Franklin PUD's Authorization for Release of Protected Health Information (PHI) from your medical provider(s) in addition to the Claim for Damages Form.
- For a vehicle collision claim, Franklin PUD's Vehicle Collision form must also be completed and submitted in addition to the Claim for Damages Form.

What if your claim is denied?

If your claim is denied, Franklin PUD's insurance company (Federated) will send a letter explaining the reason. If you are not satisfied with the decision or explanation, you have the right to file a court action, including a small claims action.

Do you have any other options?

Your own insurance company (such as homeowners, motor vehicle and extended warranty) may have coverage for your claim.

Is there a time limit on filing a claim or a court action?

It is always best to submit a claim as soon as possible. If you wish to file a court action, there are various time limits set by Washington State law. Generally, these are: personal injury, 3 years from the date of the injury; business interruption or economic loss with no property damage, 3 years; tangible property damage, 3 years. If you have questions regarding these limits, you should consult an attorney.

Who should you contact at Franklin PUD if you have more questions?

Franklin PUD's Claims Agent can be reached at phone number 509-547-5591 or at email address claims@franklinpud.com.



CLAIM FOR DAMAGES FORM PACKET

Please read carefully all instructions and form before completing and presenting your Claim for Damages.

The instructions to complete and the Claim for Damages form have been created in compliance with RCW 4.92.100 which requires citizens to present this form when filing a tort claim (Claim for Damages) against Franklin PUD. Claims for Damages may be subject to public disclosure to third parties. The Claim for Damages may be denied if incomplete information is provided.

Legal Requirements

In order to verify the claim and additional supporting information, the law requires that the Claim for Damages form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney in fact for the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant's behalf; or
- A court-approved guardian or guardian ad litem on behalf of the Claimant

Present the completed and signed Claim for Damages Form and Supporting Documents to:

Public Utility District No. 1 of Franklin County (Franklin PUD)
Attention: Claims Agent
PO Box 2407
1411 W Clark Street
Pasco, WA 99302-2407

Business Hours: Monday – Friday, 8:30am to 5pm
Closed on weekends and holidays

INSTRUCTION FOR COMPLETING THE CLAIM FOR DAMAGES FORM

- Before filing a Claim for Damages, please read these instructions, the Claim for Damages Form and other appropriate forms in their entirety.
- Please type or print **clearly** in ink and sign the Claim for Damages form.
- Provide all requested information and any available documents of evidence supporting your claim, damages, receipts/estimates for property value, pictures, etc.
- If you need more space to provide the information requested, please use additional blank sheets so your claim can be easily read and understood.
- The following is an example of how to complete the Claim for Damages Form.
 1. Jane Doe Smith
 2. 01/28/1979
 3. 12345 Road 125, Pasco, WA 99301
 4. PO Box 10203, Pasco, WA 99301-10203
 5. Same (or write in the residence address at the time of the incident, if different from your current address).
 6. (509) 555-5555 – (509) 123-4567.
 7. Jdsmith123@yahoo.com.
 8. 09/02/2013 4:30pm.
 9. If the incident occurred over a period of time, please provide the beginning date & time and ending date & time in item 8.
 10. 12345 Road 125, Pasco, WA, Franklin
 11. US 395, Southbound, Milepost 35, near Eltopia.
 12. Jane Doe Smith, 12345 Road 125, Pasco WA 99301, (509) 555-5555
Tow truck driver for A&B Towing Company
 13. List the names and contact information of any Franklin PUD employees who have knowledge about the incident. If none, or you don't know, write "Unknown".
 14. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 12 and 13. Also include a description of their knowledge. For example, if your sister was with you when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
 15. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when, why, and how.
 16. If you reported this incident to law enforcement, fire department, etc., please provide a copy of the report or contact information to the person with whom you spoke.
 17. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
 18. Franklin PUD's vehicle backed into my vehicle.
 19. Indicate whether or not you have reported this claim to your insurance company. If yes, please list the name and contact information for the insurance company.
 20. Please attach any additional documents that support your claim.
 21. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of the total compensation.
- If your claim involves a personal injury claim, please sign and attach Franklin PUD's Authorization for Release of Protected Health Information (RHI).
- If your claim involves a motor vehicle, please complete, sign, and attach Franklin PUD's Vehicle Accident Form.



CLAIM FOR DAMAGES FORM

Pursuant to Chapter 4.92 RCW, this form is for filing a tort claim (claim for damages) against Franklin PUD. The information requested on this form is required by RCW 4.92.100 and may be subject to public disclosure. Failure to provide information may result in denial of the claim. Pursuant to the law, Claim for Damages forms cannot be submitted electronically (via email or fax).

For Official Use Only

Date Received: _____

Claim No.: _____

PLEASE TYPE OR PRNT CLEARLY IN INK

Mail or Hand-Deliver original claim to Public Utility District No. 1 of Franklin County (Franklin PUD)
Attention: Claims Agent
PO Box 2407
1411 W Clark Street
Pasco, WA 99302-2407

Business Hours: Monday – Friday, 8am to 5pm
Closed on weekends and holidays

1. Claimant's name: _____

First name	Middle	Last
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2. Claimant's date of birth (mm/dd/yyyy): _____
3. Current residential address: _____
4. Mailing address (if different): _____
5. Residential address at the time of the incident: _____
(if different from current address)
6. Claimant's daytime telephone number: _____

Home	Business or Cell
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7. Claimant's email address: _____
8. Date of the incident: _____ Time: _____ a.m. p.m. (check one)
(mm/dd/yyyy)

9. If the incident occurred over a period of time, date of first and last occurrences:

From: _____ Time: _____ a.m. p.m. (check one)
(mm/dd/yyyy)

To: _____ Time: _____ a.m. p.m. (check one)
(mm/dd/yyyy)

10. Location of the incident: _____
Address City State County

11. If the incident occurred on a street or highway:

Name of street or highway Milepost number At the intersection with or
nearest intersection street

12. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

13. Names, addresses and telephone numbers of all Franklin PUD employees having knowledge about this incident:

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 above that have knowledge regarding the liability issues involved in this incident, or knowledge of the Claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

15. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

16. Has this incident been reported to law enforcement? Yes No (check one)
If Yes, when, how and to whom? Please attach a copy of the report or contact information.

17. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

18. Why do you think that Franklin PUD is responsible for this claim? Attach additional sheets if necessary.

19. Have you reported this loss to your insurance company? Yes No (check one)
If Yes, what is the name of the insurance company, address and phone number?

Insurance company name	Address	Phone Number
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20. Please attach documents including receipts and invoices for expenses which support the allegations of the claim.

21. I claim damages from Franklin PUD in the sum of \$_____.

This claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Claimant's Signature

Date and place (residential address, city & county)

OR

Claimant's Representative Signature

Date and place (residential address, city & county)

Print Name of Representative

Bar Number (if applicable)

VEHICLE COLLISION FORM



PLEASE TYPE OR PRINT IN BLUE OR BLACK INK

CLAIMANT AND INCIDENT INFORMATION	CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT)				DATE OF ACCIDENT (MM/DD/YYYY)		TIME ___AM ___PM				
	CURRENT STREET (RESIDENCE) ADDRESS			CITY	STATE	ZIP	PHONE: HOME WORK CELL				
	(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT			CITY	STATE	ZIP	EMAIL				
	STATE/COUNTY/CITY (IF APPLICABLE) WHERE OCCURRED		STREET OR HWY	MILEPOST NO.	INTERSECTION OR NEAREST STREET/ROAD						
YOUR VEHICLE INFORMATION (VEHICLE #1)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	WHERE CAN THE CAR BE SEEN?		WHEN?				
	NAME OF VEHICLE OWNER			ADDRESS	CITY	STATE	ZIP	HOME AND WORK PHONE			
	NAME OF DRIVER			ADDRESS	CITY	STATE	ZIP	HOME AND WORK PHONE			
	DRIVER'S LICENSE NUMBER			STATE OF ISSUANCE	DATE OF EXPIRATION						
	DESCRIBE THE DAMAGE					ESTIMATE \$	YOUR INSURANCE COMPANY AND POLICY NO.				
FRANKLIN PUD VEHICLE (VEHICLE #2)	YEAR	MAKE	MODEL	LICENSE PLATE NO.	FRANKLIN PUD'S INSURANCE COMPANY <i>Federated Rural Electric Insurance Exchange</i>		PHONE <i>1-800-356-9004</i>				
	NAME OF OWNER <i>Franklin PUD</i>			ADDRESS <i>1411 W Clarke Street/PO Box 2407</i>	CITY <i>Pasco</i>	STATE <i>WA</i>	ZIP <i>99302</i>	PHONE <i>509-547-5591</i>			
	NAME OF DRIVER			ADDRESS	CITY	STATE	ZIP	PHONE			
	DESCRIBE THE DAMAGE						ESTIMATE \$				
OTHER NON-VEHICLE DAMAGE	WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.										
	NAME OF OWNER			ADDRESS	CITY	STATE	ZIP	PHONE			
	DESCRIBE THE DAMAGE						ESTIMATE \$				
INJURED PARTIES	NAME		ADDRESS	PHONE	INJURY	AGE	VEH1	VEH2	VEH3	PED	OTH
				HOME WORK							
				HOME WORK							
				HOME WORK							
				HOME WORK							
				HOME WORK							
WITNESSES	NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY)			ADDRESS	CITY	STATE	ZIP	PHONE			
								HOME WORK			
								HOME WORK			

COMPLETE ALL DETAILS

Describe the conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

Road Design				Circle the Damaged Areas					
<input type="checkbox"/> Straight road <input type="checkbox"/> Curve – R or L <input type="checkbox"/> Level		<input type="checkbox"/> Hillcrest <input type="checkbox"/> Uphill <input type="checkbox"/> Downhill		<input type="checkbox"/> One Lane <input type="checkbox"/> One and One-Half Lane <input type="checkbox"/> Two Lane or Four Lane		Vehicle #1 Vehicle #2			
<p>IMPORTANT: If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.</p> <div style="border: 1px dashed black; padding: 5px; width: 100%;"> <p style="text-align: center;">Street Center</p> <hr style="border-top: 1px dashed black;"/> <p style="text-align: center;">Sidewalk</p> <hr style="border-top: 1px solid black;"/> </div> <p style="text-align: center;">Show on the diagram the position of each vehicle or injured person, indicating with an arrow the direction of each.</p> <div style="text-align: center;"> <p style="text-align: center;">Indicate points of compass N. E. S. W.</p> </div>				Front Front					
LIGHT CONDITIONS (CHECK ONE)	TRAFFIC CONTROL (CHECK ONE OR MORE)		TYPE OF ROAD (CHECK ONE OR MORE)		VEHICLE CONDITION (CHECK ONE OR MORE)		ROAD SURFACE (CHECK ONE)	WEATHER (CHECK ONE)	
1 DAYLIGHT <input type="checkbox"/>	VEHICLE #1 #2		VEHICLE #1 #2		VEHICLE #1 #2		VEHICLE #1 #2		
2 DAWN <input type="checkbox"/>	<input type="checkbox"/> 1	<input type="checkbox"/> SIGNALS	<input type="checkbox"/> 1	<input type="checkbox"/> ONE WAY	<input type="checkbox"/> 1	<input type="checkbox"/> DEFECTIVE BREAKS	<input type="checkbox"/> 1	<input type="checkbox"/> DRY	1 <input type="checkbox"/> CLEAR, CLOUDY & OVERCAST
3 DUSK <input type="checkbox"/>	<input type="checkbox"/> 2	<input type="checkbox"/> STOP SIGN	<input type="checkbox"/> 2	<input type="checkbox"/> TWO WAY	<input type="checkbox"/> 2	<input type="checkbox"/> DEFECTIVE HEADLIGHTS	<input type="checkbox"/> 2	<input type="checkbox"/> WET	2 <input type="checkbox"/> RAINING
4 DARK--STREET LIGHTS ON <input type="checkbox"/>	<input type="checkbox"/> 3	<input type="checkbox"/> FLASHING RED	<input type="checkbox"/> 3	<input type="checkbox"/> REVERSIBLE ROAD	<input type="checkbox"/> 3	<input type="checkbox"/> DEFECTIVE REAR LIGHTS	<input type="checkbox"/> 3	<input type="checkbox"/> SNOW	3 <input type="checkbox"/> SNOWING
5 DARK--STREET LIGHTS OFF <input type="checkbox"/>	<input type="checkbox"/> 4	<input type="checkbox"/> FLASHING AMBER	<input type="checkbox"/> 4	<input type="checkbox"/> INTERCHANGE LOOP RAMP	<input type="checkbox"/> 4	<input type="checkbox"/> TIRES WORN	<input type="checkbox"/> 4	<input type="checkbox"/> ICE	4 <input type="checkbox"/> FOG
	<input type="checkbox"/> 5	<input type="checkbox"/> RAILROAD SIGNAL	<input type="checkbox"/> 5	<input type="checkbox"/> ALLEY	<input type="checkbox"/> 5	<input type="checkbox"/> PUNCTURED OR BLOWN TIRES	<input type="checkbox"/> 5	<input type="checkbox"/> OTHER (SPECIFY)	5 <input type="checkbox"/> OTHER (SPECIFY)
6 DARK--NO STREET LIGHTS <input type="checkbox"/>	<input type="checkbox"/> 6	<input type="checkbox"/> OFFICER/ FLAGMAN	<input type="checkbox"/> 6	<input type="checkbox"/> TWO WAY- LEFT TURN LANES	<input type="checkbox"/> 6	<input type="checkbox"/> OTHER	NAME OF INVESTIGATING POLICE AGENCY:		
	<input type="checkbox"/> 7	<input type="checkbox"/> YIELD SIGN	<input type="checkbox"/> 1	<input type="checkbox"/> SEPARATED	INVESTIGATING AGENCY REPORT NO.:				
<input type="checkbox"/> 8	<input type="checkbox"/> NO TRAFFIC CONTROL	<input type="checkbox"/> 2	<input type="checkbox"/> DIVIDED						
7 OTHER SPECIFY <input type="checkbox"/>	<input type="checkbox"/> 9	<input type="checkbox"/> OTHER	<input type="checkbox"/> 3	<input type="checkbox"/> UNDIVIDED					

A separate claim form must be completed for each claimant.

This information is being provided to aid in resolving the claim.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant _____

Date and Place (residential address, city and county) _____

I understand the following: (Please read and initial all statements)

- _____
Initials I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).
- _____
Initials I understand that my health information may be subject to re-disclosure by Franklin PUD and not protected for purposes of evaluating and investigating the claim I have filed with Franklin PUD.
- _____
Initials I understand that the specific information to be disclosed in my medical records may include information regarding alcohol, drug or other controlled substance use, counseling referrals, and/or a history of testing or treatment of acquired immune deficiency syndrome.
- _____
Initials I understand that I may revoke this authorization at any time by notifying Franklin PUD's Claims Agent in writing, and that the revocation will be effective as of the date the Claims Agent receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.
- _____
Initials I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by Franklin PUD.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to Franklin PUD.

Signature of Authorizing Individual: _____

Date of Signature: _____ Telephone number: _____

Witness (where patient is over 13 and signing the release):

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- Parent of minor
- Legal Guardian
- Personal Representative
- Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Public Utility District No. 1 of Franklin County
Claims Agent
1411 W Clark Street
PO Box 207
Pasco, WA 99302-2407