TORTS PACKET

General Guidelines for Filing:

Two Year Rule: You have a time limit of 2 years from the date of the incident to submit your claim to our office.

Estimate of Repair/Replacement: This office requires one written estimate of repair for damaged personal property. If an item is not repairable, the estimate should so state and include a written replacement cost. If an automobile is totaled, a salvageable cost is required.

Duty to Mitigate Damages: Claimants have a duty to mitigate damages. Except when expressly authorized by a claims attorney, ***automobile storage costs will not be reimbursed once it has been determined that an automobile has been totaled.***

Documents required to be filed with the Claim (If Applicable):

a. SF 95 Claim for Damage, Injury, or Death. Please complete both sides. Each SF 95 is for a single claimant and must have a date, signature, and an exact amount in block 12d.

b. A copy of the vehicle registration.
c. A copy of the vehicle insurance card ***or*** insurance policy (Declaration page only).
d. A copy of any insurance settlement and check (if applicable).
e. A written estimate of repair or replacement. See Note Above.
f. Rental car and towing receipts.
g. Photographs of the damaged areas of the property.
h. Release of medical records and billing statements (if applicable). See directions on reverse side.
i. A copy of the police report, military police report, accident report, or any other document supporting the basis of the claim (e.g., DEH report, AAFES incident report, or hospital memorandum).

Fort Bragg Claims Office Hours of Operation:

Monday and Tuesday: 0900 - 1600hrs
Wednesday: 1300 - 1600hrs
Thursday: 0900 - 1500hrs
Friday: 0900 - 1200hrs
Closed daily from 1200 - 1300 for lunch

Directions

Please fill out and complete both sides of the included Standard Fonn (SF 95). All claims include a signature, date, and the exact amount being claimed in block 12d. If this information is not provided, no claim will have been filed and the Statute of Limitations will continue to run.

Complete the included Damages Worksheet. If none of the categories describe your damage, add your description to the worksheet.

A "power of attorney" is required if someone other than the owner/injured is filing the claim.

For personal injury claims, no claim for personal injury may be processed without a signed Release of Medical Records. Please read the enclosed information regarding the Health Insurance Portability and Accountability Act (HIPPA). An attached worksheet is provided on which to list medical records.

If an insurance company is filing a claim on behalf of its insured, or a claim based on subrogation rights, it must provide written authorization of subrogation rights. Also, written authorization must be provided showing that the claims adjudicator or company representative has authority to sign the SF 95 on behalf of the company. If insurance company is collecting the deductible for its insured, it must provide written authorization, signed by the insured, to collect the sum total of the deductible.

For any questions, or further assistance, please call us at (910) 396-7505.

PLEASE NOTE

Filing a Claim is no guarantee of Payment.

The average processing time for a tort claim is between two and four months after all necessary documents are submitted. Some claims take longer due to their complexity.

Payment usually take place six to eight weeks after a claim has been settled, but may take longer.

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:

Office of the Staff Judge Advocate
ATTN: AFZA-JA-B (Tort Claims)
4-2175 Reilly Road, Stop A
Fort Bragg, NC 28310-5000

2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.

SSN:_____ Rank:_____

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☐ CIVILIAN				

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

Email Address:_____

9. PROPERTY DAMAGE

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side).

(List year, make and model of vehicle along with a brief description of the damages).

10. PERSONAL INJURY/WRONGFUL DEATH

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

(If no personal injury, list "N/A" for not applicable -- DO NOT LEAVE BLANK).

11. WITNESSES

NAME	ADDRESS (Number, Street, City, State, and Zip Code)

12. (See instructions on reverse). AMOUNT OF CLAIM (In dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights).

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).	13b. PHONE NUMBER OF PERSON SIGNING FORM	14. DATE OF SIGNATURE
(Original Ink)	(H): (W):	

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of the vehicle or property.

15. Do you carry accident insurance? ☐ Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number. ☐ No

16. Have you filed a claim with your insurance carrier in this instance, and if so, is it full coverage or deductible? ☐ Yes ☐ No

17. If deductible, state amount.

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts).

19. Do you carry public liability and property damage insurance? ☐ Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code). ☐ No

INSTRUCTIONS

Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form.

Complete all items - Insert the word NONE where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item number 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of the injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

***(d)* Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.**

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid."

PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, DC 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

DAMAGE WORKSHEET

**Please complete this form in conjunction with the SF95 and attach to the same. **

NAME: _____

PROPERTY

1) Vehicle Damages _____

2) Towing _____

3) Rental _____

4) Estimate Fees _____

Total _____ = 12(a)

PERSONAL INJURY

1) Medical Care _____

2) Medication _____

3) Chiropractic Care _____

4) Pain and Suffering _____

5) Loss of Wages _____

Total _____ = 12(b)

WRONGFUL DEATH

Total _____ = 12(c)

Total Amount Claimed _____ = 12(d)

_____ _____

Claimant Signature Date

Health Information Privacy and Procedures

Effective April 14, 2004

1. This notice describes how medical information about you may be used and disclosed and is provided as a requirement of the Health Insurance Portability and Accountability Act (HIPPA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. You have the right to approve or refuse the release of protected health information, except when the release is required or authorized by law or regulation.

2. You are asked to provide a signed acknowledgement of this notice and consent to release your protected health information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The processing of your administrative claim against the United States is conditioned upon your agreement to disclose your protected health information. If you decline to provide a signed agreement, we may be unable to proceed with the investigation and evaluation of your claim.

3. **General Rule: No Use or Disclosure.** The United States Army claims offices must not use or disclose protected health information (PHI), except as these Privacy Policies & Procedures permit or require.

4. **Acknowledgements and Optional Consent:** The United States Army claims offices will make a good faith effort to obtain a written acknowledgement of receipt of our *Notice of Privacy Practices* from a medical consultant or other business associates before we use or disclose your protected health information for the purposes of investigating and evaluating your claim against the United States.

5. **Authorization Revocation:** You may revoke an authorization at any time by written notice to the claim office where you filed your claim. However, such revocation may cause the United States Army not be able to complete its investigation and evaluation of your claim against the United States, and may result in a denial of your claim. Our offices will not rely on an Authorization we know has been revoked.

6. **Authorization from another Agency or Entity:** According to the Federal HIPPA Law, U.S. Army claims offices will use or disclose PHI as permitted by law to other agencies, entities or professional financial or medical consultants. For example, to a medical consultant for review of your medical care, to a medical physician should you be required to undergo an independent medical examination, to a financial consultant, structured settlement broker, trustee or trust administrator, or other professional consultant/associate for the evaluation of your claim or the administration of the terms of your settlement, resulting from your claim against the United States.

7. **Verification of Identity:** U.S. Army claims offices will always verify the identity of the person, unknown to us, who request PHI before we will disclose the PHI to that person.

8. **Required Disclosures:** U.S. Army claims offices may use or disclose PHI, provided procedures specified in the Privacy Rules are followed, to the following, if required by law or during the course of the investigation and evaluation of your claim:

(1) To health oversight agencies;

(2) In response to subpoenas and other lawful judicial processes;

(3) To law enforcement agencies;

(4) To officials within the Department of Army of Defense; and

(5) As required by law.

9. **Required Disclosures:** U. S. Army claims offices will disclose protected information (PHI) to you and your attorney, if appropriate, (to the extent you have a right to access of the PHI); and to the U.S. Department of Health and Human Services (HHS) on request for complaint investigation or compliance review.

10. **Minimum Necessary:** U.S. Army Claims offices will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary protected health information (PHI) to accomplish the intended purpose.

11. **Business Associates:** U.S. Army Claims offices will obtain satisfactory assurances in the form of a written contract that our consultants and associates will appropriately safeguard and limit their use and disclosure of the protected health information (PHI) we disclose to them. The contracts utilized contain the terms that federal law requires to be included in each contract.

12. **Research.** We may disclose your protected health information to U.S. Army researchers by law, for example, the United States Army consultation Care Review Brach of the Office of the Surgeon General or the Armed Forces Institute of Pathology, for review of your protected health information (PHI).

13. **Right to an Accounting of Disclosures.** You may request that we provide you with an accounting of the disclosures we have made of your protected health information for the purposes other than those described in this notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request.

14. **Federal Privacy Laws:** This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accounting Act (HIPPA). There are several other privacy laws that also apply including the Freedom of Information Act, the

Privacy and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act.

15. **Complaints:** If you believe these privacy rights have been violated, you may file a written compliant with the U.S. Army Claims office where you filed your claim, or the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

Release of Medical Records

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), the health care providers and/or medical facilities listed on the attached sheet are hereby authorized to release to the United States Department of the Army, and its claims representatives, all medical and dental records, including but not limited to in-patient records, out-patient records, office notes, history and physical examination notes, consultation notes, admission and discharge summaries, order and progress notes, laboratory results, nurses notes, emergency room records, operative records, and radiology films and study results (including x-ray, CT, MRI, and PET studies), medical bills, health insurance, Medicaid, and Medicare records, concerning any medical treatment that (**Name of Patient**_____) has received from the health care providers or medical facilities listed above, as well as all such records kept in the regular course of business and are contained in his/her medical records file. I further authorize release of all records regarding mental health, psychiatric (other than psychotherapy notes which must be requested separately), chemical dependency, or HIV.

I further understand that any medical records and information provided to the United States Department of the Army, and its claims representatives, may be copied and shared with medical reviewers and consultants for purposes of evaluating a personal injury or wrongful death administrative claim for compensation submitted to that agency. I authorize the United States Department of the Army, and its claims representatives, to release medical records and information to medical reviewers and consultants for said purpose. I understand that any disclosure of information to medical reviewers and consultants carries the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Attached is an explanation of HIPPA which as evidence by my signature below indicates that I have read the attached explanation of my privacy rights under HIPPA.

A photostatic copy of this document shall be as valid as the original. I understand that I have the right to revoke this authorization by providing a signed, written notice of revocation to the health care providers and facilities listed above. Unless rescinded in writing, this authorization will remain in effect until such time that a final resolution of my administrative claim for compensation has been determined by the United States.

_____ _____

Printed Name of Patient | Social Security Number

_____ _____

Signature of Patient (If Signed by a Legal Representative, List Relationship to Patient) | Patient's Date of Birth

_____

Date Signed

Provided Medical Records of _____
Claim Number _____

1. Military Records:

Dates of Treatment	Name of Military Treatment Facility

2. Radiology films (MRI/CT Scans, slides or electronic images):

Dates of Treatment	Name of Military Treatment Facility

3. Civilian Records:

Dates of Treatment	Civilian Records

4. Radiology films (MRI/CT Scans, slides or electronic images):

Date of Treatment	Name of Treatment Facility