

CSU CLAIM FORM

IS YOUR CLAIM COMPLETE?

	Include a check or money order for \$25 payable to "Trustees of the CSU."
	Complete all sections relating to this claim and sign the form. Please print or type all information.
	Attach receipts, bills, estimates, pictures or other documents that back up your claim.

CLAIMANT INFORMATION

LAST NAME		FIRST NAME		
TELEPHONE NUMBER		EMAIL ADDRESS		
MAILING ADDRESS		CITY	STATE	ZIP
IS THE CLAIMANT UNDER 18 YEARS OF AGE?		IF YES, GIVE DATE OF BIRTH:		
	YES		NO	

ATTORNEY OR REPRESENTATIVE INFORMATION

LAST NAME		FIRST NAME		
TELEPHONE NUMBER		EMAIL ADDRESS		
MAILING ADDRESS		CITY	STATE	ZIP

CLAIM INFORMATION

Is your claim for a stale-dated warrant (uncashed check)?			YES		NO
CSU Campus that issued the warrant:		If NO continue to Next Section			
Dollar amount of warrant:		Date of issue:			
Proceed to Notice and Signature Section					

Date of Incident:					
Was the incident more than six months ago?			YES		NO
If YES , did you attach a separate sheet with an explanation for the late filing?			YES		NO
CSU Campus or CSU employees against whom this claim is filed:					
Dollar amount of claim:					
If the amount is more than \$10,000, indicate the type of civil case:		Limited civil case (\$25,000 or less)			
		Non-limited civil case (over \$25,000)			
Explain how you calculated the amount:					
Location of the incident (be as specific as possible if referencing a campus location):					

Describe the specific damage or injury (attach additional pages as necessary):			
Explain the circumstances that led to the damage or injury (attach additional pages as necessary):			
Explain why you believe the CSU is responsible for the damage or injury (attach additional pages as necessary):			
Does the claim involve a campus vehicle?		YES	NO
If YES, provide the vehicle license number, if known:			

AUTO INSURANCE INFORMATION

Name of Insurance Carrier			
Mailing Address		City	State Zip
Policy Number:		Telephone Number:	
Are you the registered owner of the vehicle?		YES	NO
IF NO, state name of owner:			
Has a claim been filed with your insurance carrier, or will it be filed?		YES	NO
Have you received any payment for this damage or injury?		YES	NO
If YES, what amount did you receive?			
Amount of deductible, if any:			
Claimant's Driver's License Number?		Vehicle License Number:	
Make of Vehicle:		Model:	Year:
Vehicle ID Number:			

FOR BODILY INJURY CLAIMS ONLY (PURSUANT TO THE MEDICARE SECONDARY PAYER ACT):

If a claim for bodily injury is being made:			
Date of Birth:		Social Security Number:	

NOTICE AND SIGNATURE

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true and correct to the best of my information and belief. I further understand that if I have provided information that is false, intentionally incomplete or misleading, I may be charged with a crime punishable by up to one year in state prison and/or a fine up to \$10,000 (Penal Code section 72).	
Signature of Claimant or Representative	Date

Mail the original completed form and all attachments with the \$25 filing fee or the "CSU Affidavit for Waiver of Filing Fee" request to: CSU Office of the Chancellor, Systemwide Risk Management, 401 Golden Shore, 5th Floor, Long Beach CA 90802-4210. Keep a copy for your records.