FINANCIAL CLAIM FORM

PLEASE MAIL CLAIM FORM WITHIN 30 DAYS OR RESTITUTION MAY NOT BE ORDERED

☐ **CHECK HERE AND RETURN CLAIM FORM IMMEDIATELY IF THERE IS NO FINANCIAL CLAIM**

Loss sustained by_____

Name of alleged delinquent(s)_____

Description of loss: *Please itemize and attach bills, receipts and/or estimates. List your losses after deducting any payments you have received or expect to receive from insurance. (If you have insurance, you must utilize it first.) Loss of wages, vacation or sick time or car rentals cannot be reimbursed through restitution.*

_____ **$**_____

_____ **$**_____

_____ **$**_____

_____ **$**_____

_____ **$**_____

After loss of wages (including employee wage reimbursement for involvement) **Total loss $**_____

Insurance Information

Is loss covered by insurance: _____☐ yes_____☐ no _____☐ in part

Amount of claim presented to insurance company $_____

Amount of claim paid by insurance $_____ Amount of deductible $_____

Name of insurance company_____

Address_____

Phone#_____ Policy number_____

This section must be completed before restitution can be ordered

If claim was not covered by insurance, briefly describe why_____

_____

_____

Restitution to be paid to:

Name_____ Home phone_____Work phone_____

Address_____ email address_____

_____

I herby declare the above information to be true.

_____

Signature ☐ By checking this box the typed name entered above is your electronic signature.

Contact Carol Aversa for assistance
610-630-2252, ext. 7675
caversa@montcopa.org

FOR OFFICE USE ONLY

Claim approved for $_____ Date_____

Approved by_____

UPON COMPLETION OF THIS FORM, PLEASE RETAIN THE PINK COPY FOR YOUR RECORDS!