INSTRUCTIONS FOR ALABAMA DEPARTMENT OF TRANSPORTATION (ALDOT)

CLAIM FOR PERSONAL INJURY AGAINST ALDOT

NOTE: Claims must be presented within one year after the date of the injury or within two years for claims for injury resulting in death. Each question must be answered. If all questions are not answered, the claim will not be accepted. Forms must be printed in ink or typed. All supporting documentation must be submitted on 8 ½ x 11 paper front side only.

**********Claim forms must be accompanied by all the required documentation or your claim will be returned requesting further information. Any delays could cause the dismissal of your claim.

Please fill out the attached Personal Injury Form and file it as directed below.

CLAIMS $5,000.00 OR LESS

MAIL COMPLETED FORMS TO:
Alabama Department of Transportation
Legal Bureau
1409 Coliseum Boulevard
Montgomery, AL 36110

FORMS MAY BE E-MAILED TO:
claims@dot.state.al.us

FORMS MAY BE DELIVERED TO:
Legal Bureau
1409 Coliseum Boulevard
Montgomery, AL 36110
Telephone Number: (334) 242-6350
Fax: (334) 264-4359

CLAIMS GREATER THAN $5,000.00

MAIL COMPLETED FORMS TO:
Alabama State Board of Adjustment
600 Dexter Avenue, Suite E-302
Montgomery, AL 36130-1435

FORMS MAY BE DELIVERED TO:
Alabama State Board of Adjustment
State Capitol Building, Suite E-302
Montgomery, AL 36130
Telephone Number: (334) 242-7175
Fax: (334) 242-2008

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1. Identify whether your claim is greater or less than $5,000.

2. Enter your personal information. Enter your Name, Address, Telephone Number(s), Email Address, the last four digits of your Social Security Number or the last four digits of your FEIN if a business. Claims without the last four digits cannot be processed and will be returned to the Claimant. If injured party is a minor, enter the name and age of the minor and the name and relationship of person with whom minor lives.

3. If you have an attorney, enter your attorney's information. (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

4. Enter the facts of the claim:

   A. Enter the date the injury occurred.

   B. Enter the location and address where the injury occurred. (Example: Lunchroom at City Elementary, City, Alabama 36000)

   C. A statement of facts describing the injury and the events surrounding the injury. Documentation must accompany the claim for proof of the injury. Provide an official accident or incident report, a report from a representative of the agency or some other official and any other evidence to prove that the incident upon which the claim is based took place. (Example: Dated and signed witness statements.)

5. If this was an on-the-job injury, use Alabama State Board of Adjustment Claim for On the Job Injury form. This form can

be found on the Board of Adjustment web site, www.bdadj.alabama.gov. Otherwise, check no and continue.

6. If you incurred lost wages as a result of your injury, enter the following information:

   A. Enter the name and address of your employer.
   B. Enter your job title at the time of the injury.

7. Medical Expenses: Enter all medical expenses incurred as of a result from the injury. Include additional sheets if necessary. List each health care provider, including pharmacy, and the amount charged by each. You must provide evidence (itemized bills) to show what treatment was provided, when it was provided, and the charge, as well as evidence of insurance filing and payments (insurance company summary sheets). Alabama Department of Transportation and the Alabama State Board of Adjustment will not make awards for expenses paid by private insurance. If claimant is not covered by insurance, this should be clearly stated.
   A. Enter the Total of Medical Expenses Claimed

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you**.**
   A. Enter the Total Payments Made to You from All Insurance Companies

9. Medical Disability: If you are claiming medical disability, you MUST complete this section.

   A. If you are claiming damages for permanent disability, check "Yes"; otherwise, check "No.
   B. If you have claimed compensation for permanent disability from any source, such as Social Security Disability, Workers Compensation, etc., check "Yes"; otherwise, check "No".
   C. Enter the amount you are seeking for permanent or total disability.
   D. Describe the permanent disability. Evidence (usually a letter, statement, or report from physician) that claimant has reached maximum medical improvement "MMI" and is left with a disability stated in percentage of physical impairment to the whole body or part of body involved (arm, leg, finger, etc.).

10. Wages: If you are claiming lost wages and/or compensation for leave used, list each separately. Evidence from doctor or other healthcare provider that Claimant was unable to work because of the accident/injury stated, verification from the employer of the time lost from work or the leave deducted and verification from the employer of the Claimant's rate of pay at the time of the accident/injury.

    A. Enter the amount of wages you lost due to the injury. Circle whether the amount you have entered is for hours, days or weeks. (Example: $25 for 2 Hours)
    B. Enter the amount of leave used. (Example: 16 hours for 2 days)
    C. Enter your rate of pay at the time of your injury. Check the box indicating whether the amount is per hour, day, or week. (Example: $12.50 per hour)
    D. Enter the total of wages lost due to the injury.

11. Enter any miscellaneous expenses associated with the personal injury, such as damages to automobile, eyeglasses, mileage, etc. Note: If claiming mileage, use the Mileage Log which is listed on the website, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

    A. Provide the total amount of miscellaneous expenses claimed.
    B. If any of the listed expenses are covered by insurance, please check "Yes"; otherwise, check "No".
    C. If you answered "Yes" in Item 11.B., list the amount of insurance coverage and your deductible. (For damages to personal property, it will be necessary to provide a copy of your insurance declaration page which indicates your amount of coverage and your deductible.)

12. Enter the GRAND TOTAL amount you are claiming for all items described in Items 7.A., 8.A., 9.C., 10.D., and 11.A.

13. Sign the claim form in the presence of a Notary Public, print your name and have the notary complete the verification section.

14. Complete a current W-9. Completion of the W-9 will expedite payment of your claim in the event the Department pays your claim. You can find a current W-9 form on the IRS website at https://www.irs.gov/forms-pubs/about-form-w-9

ALABAMA DEPARTMENT OF TRANSPORTATION (ALDOT)
CLAIM FOR PERSONAL INJURY AGAINST ALDOT

See Page 1-2 of this form for instructions. Each number on the form corresponds with numbers on instruction sheets. Read all instructions carefully to ensure your claim is not returned for additional supporting documentation. See INSTRUCTIONS for mailing or hand delivering this form. (Page 1).	**DO NOT WRITE IN THIS SPACE. FOR ALDOT USE ONLY.** **Claim No.:**_____

1. Please check whether your claim is: ☐ $5,000.00 or less ☐ greater than $5,000.00
2. Claimant's Information:

   Name: _____

   Street Address or P.O. Box: _____

   City, State, Zip Code: _____ E-mail_____

   Home Telephone No.:_____ Work No.:_____

   Cellular Telephone No.:_____ Fax No.:_____

   Claimant's Last Four Digits of Social Security No. or last four digits of Business FEIN:

   SSN: XXX-XX-_____ FEIN: XX-XXX _____

   If injured party is a minor (under 19 years of age), claim must be signed and filed by parent or guardian as claimant. Give name and age of minor and the name and relationship of person with whom minor lives.

   Name of Minor:_____ Age of Minor: _____

   Name of Person with whom Minor Lives: _____

   Relationship of Person to Minor: _____

3. Claimant's Attorney: (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

   Attorney Name: _____

   Street Address of P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Office Telephone No.:_____ Fax No.: _____

4. Facts of Claim:

   A. Date of Injury: _____

   B. Location and Address of Injury: _____

   C. Statement of Facts (Describe the injury and the events surrounding the injury): _____

   _____

   _____

Claimant's Name_____

5. Was this an on-the-job injury? ☐ Yes ☐ No
   If you answered yes, stop now and use the Claim form for On the Job Injury form. See instructions for this on page 1 of this form.

6. Employer Information (if lost wages were incurred):

   A. Name, Address & Telephone Number of Employer: _____

   _____

   _____

   B. Job Title at the Time of the Injury: _____

7. Medical Expenses (List each health care provider, including pharmacy, and the amount charged by each. Include additional sheets if necessary):

Provider	Amount of Expense

   A. Total of Medical Expenses Claimed: _____

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid you:

Name of Insurance Company (Includes AllKids, Medicare, Medicaid)	Amount Paid to You

   A. Total Payments Made To You from All Insurance Companies: _____

9. Medical Disability:

   A. Are you claiming damages for permanent disability? ☐ Yes ☐ No

   B. Have you claimed compensation for permanent disability for this injury from any other source, such as Social Security Disability, Workers Compensation, etc.? ☐ Yes ☐ No

   C. What is the amount you are seeking for permanent or total disability? _____

D. Describe the permanent disability: _____

_____

_____

10. Wages (If you are claiming lost wages and/or compensation for leave used, list each separately):

A. Amount of lost wages:_____for_____hours/days/weeks

B. Amount of leave used:_____for_____hours/days/weeks

C. Rate of Pay at time of Injury:_____ per ☐ Hour ☐ Day ☐ Week

D. Total Wages Claimed: _____

11. Miscellaneous Expenses: (List other expenses you are claiming and the amount for each such as damages to auto, eyeglasses, mileage, etc.) If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

Item	Amount of Expense

A. Total Amount of Miscellaneous Expenses Claimed: _____

B. Are any of the expenses listed above covered by insurance? ☐ Yes ☐ No

C. If yes, list amount of coverage and deductible amount:

Amount of Coverage: _____

Comprehensive Deductible:_____Collision Deductible: _____

D. The Department reserves the right to forward a copy of an award of damages to your insurance company.

E. By signing this form, Claimant agrees that or he, she or company will not file a claim against its insurance provider if the full amount of damages claimed is paid by the Department.

12. What is the **GRAND TOTAL** amount you are claiming for all items described in Items 7.A., 9.C., 10.D., & 11.A.?

_____

13. Signature of Claimant/Authorized Representative: _____

Please Print Name: _____

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VERIFICATION

STATE OF _____
COUNTY OF _____

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all the above-stated facts are true and correct.

Sworn and subscribed before me this_____day of_____, 20 _____

Signature of Notary Public _____

AFFIX SEAL

Printed Name _____