FEDERAL TORT CLAIMS ACT CLAIMS PROCEDURES

Claims for property damage and/or personal injury or wrongful death caused by the negligence of a government employee acting within the scope of employment are payable under the Federal Tort Claims Act (FTCA) or the Military Claims Act (MCA). A claim must be presented to the NLSO or other appropriate federal agency within 2 years of accrual. The proper format for filing a claim is a completed Standard Form 95 (SF-95). A blank SF-95 is attached. By federal law, we have six months from the date the claim is properly presented to take action on the claim. In order for us to adjudicate your claim fairly and quickly, please fill out the SF-95 according to the following directions, and attach all requested documents:

1. **Block 1** - Commanding Officer
   Naval Legal Service Office, Mid-Atlantic
   Attn: Federal Tort Claims Division
   9620 Maryland Avenue, Suite 100
   Norfolk, VA 23511-2989

2. **Block 2** - Name and current mailing address of claimant (or authorized agent, or legal representative). If authorized agent, provide evidence establishing express authority to act for claimant, showing title/legal capacity of person signing with evidence of authority to present a claim. The following forms are attached for your convenience, and use as required:

   Authority to File Claim (for authorized agents)
   Attorney Authorization (for legal representatives)
   Authorization for Insurance Company to Include Deductible in Subrogation Claim

   *Please note that only the registered owner of a vehicle (or subrogated insurance company) may file a claim for damages to that vehicle, regardless of who was driving the vehicle at the time of the incident.

3. **Block 3** - Check whether claimant was a member of the armed forces on active duty or a civilian employee of the United States government at the time of the incident

4. **Block 4** - Claimant's date of birth

5. **Block 5** - Claimant's marital status

6. **Block 6** - Fill in day and date of accident/incident when claim accrued

7. **Block 7** - Fill in approximate time of accident/incident when claim accrued
8. **Block 8** - Provide detailed facts that form the basis of your claim. Identify all people involved to the best of your ability, and city and state of occurrence. Attach the police report/incident complaint report or accident information exchange sheet, if you have one. The law requires that the Department of the Navy independently investigate each claim presented. All claims filed under the FTCA are thoroughly investigated. The more information you can provide to us regarding the government employee involved (name, duty station, phone number, etc.) the faster we can complete our investigation. Without sufficient information to investigate, we cannot adjudicate your claim.

9. **Block 9** - If you are not claiming property damage, please fill in “not applicable” or “N/A.” If you are claiming property damage, please provide ownership information and describe the damage and its location. Also attach the following required information:

   a. Proof of ownership of property involved (copy of title or registration, or copy of insurance coverage for insurance company claimants). Please note that only the registered owner of a vehicle (or subrogated insurance company) may file a claim for damages to that vehicle, regardless of who was driving the vehicle at the time of the incident;

   b. Copies of **two** separate itemized estimates for repair, or a copy of an itemized paid receipt. If the property is not economically repairable, or is lost or destroyed, provide a written statement by a dealer/mechanic/appraiser as to value of property, date of purchase, and original cost; and

   c. Any other paid receipts for expenses related to damage (i.e. towing fee, reasonable rental car receipts, etc.).

10. **Block 10** - If you are not claiming personal injury or wrongful death, please fill in “N/A.” If you are claiming personal injury or wrongful death, please state the nature and extent of each injury or cause of death. Also attach the following required information:

    a. Copies of claimant’s complete medical records, both inpatient and outpatient related to this accident;

    b. Provide a written report by claimant’s attending physician(s) or other medical professional setting forth the nature and extent of the injury, nature and extent of treatment, any degree of temporary or permanent disability, the prognosis, period of hospitalization, any diminished earning capacity, and a statement of expect expenses for any future treatment required;

    c. Itemized bills for medical, dental, and hospital expenses incurred, or itemized receipts of payments for such expenses;
d. If claiming lost wages, provide a written statement from claimant’s employer showing job description, actual time lost from employment, and wages/salary actually lost. If claiming loss of self-employed income, provide documentary evidence showing amount of earnings actually lost, including tax returns.

11. **Block 11** - List names and addresses of any witnesses. If none, fill in “N/A” or “unknown.”

12. **Block 12** - 12a. Total property damage claimed. If none, fill in “N/A.”
   12b. Total personal injury claimed. If none, fill in “N/A.”
   12c. Total amount for wrongful death claimed. If none, fill in “N/A.”
   12d. Total amount claimed (12a + 12b + 12c). **You must demand a sum certain dollar figure.** Approximate amounts or “see attached” are not acceptable. Failure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

13. **Blocks 13a and 13b** - Original signature of claimant (or authorized representative) required. Faxed or photocopies are not acceptable. Provide telephone number where claimant can be reached.

14. **Block 14** - Fill in date claim is signed by claimant.

15. **Blocks 15 -19** - Complete requested insurance information.

If you have any questions concerning your claim, please contact our FTCA Claims Division at (757) 444-5341, DSN 564-5341, or by fax at (757) 444-4421. Please understand that filing a claim is **not** a guarantee of payment. You will be notified if your claim will be settled or denied. Send your completed SF-95 and all attached documentation to:

   Commanding Officer
   Naval Legal Service Office, Mid-Atlantic
   Attn: Federal Tort Claims Division
   9620 Maryland Avenue, Suite 100
   Norfolk, Virginia 23511-2989

Enclosures:  (1) Blank SF-95
            (2) Authority to File Claim
            (3) Attorney Authorization
            (4) Authorization for Insurance Company to Include Deductible in Subrogation Claim
### 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

**EXPIRES 4-30-88**

1. **Submit To Appropriate Federal Agency:**
   OFFICE OF THE JUDGE ADVOCATE GENERAL
   TORT CLAIMS UNIT NORFOLK
   9620 MARYLAND AVENUE SUITE 100
   NORFOLK VA 23511-2989
   (757) 444-5341 (DSN 564-5341)
   FAX: (757) 444-4421

2. **Name, Address of claimant and claimant’s personal representative, if any.** (See instructions on reverse.) (Number, street, city, State and Zip Code)

3. **TYPE OF EMPLOYMENT**
   - [ ] MILITARY
   - [ ] CIVILIAN

4. **DATE OF BIRTH**

5. **MARTIAL STATUS**

6. **DATE AND DAY OF ACCIDENT**

7. **TIME (A.M. OR P.M.)**

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.)

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 DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See Instructions on reverse side.)

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

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 ACCIDENT 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 signatory
14. **DATE OF CLAIM**

**CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM**
   The claimant shall forfeit and pay to the United States the sum of $2,000, plus double the amount of damages sustained by the United States. (See 31 U.S.C. 3729.)

**CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS**
   Fine of not more than $10,000 or imprisonment for not more than 5 years or both. (See 18 U.S.C. 287, 1001.)
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".

INSTRUCTIONS

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 DUTY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANYING A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN, FOR INJURY 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.

Any instructions or information necessary in the preparation of your claim will be furnished, upon request, by the office indicated in item #1 on the reverse side. Complete regulations pertaining to claims asserted under the Federal Torts Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplemental regulations also. 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 said 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 claim for both personal injury and property damage, claim for both must be shown in item 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 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 completely execute this form or to supply the requested material within two years from the date the allegations accrued may render your claim "invalid". A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

Failure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

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 his 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 claim on your insurance carrier in this instance, and if so, is it full coverage or deductible?

17. If deductible, state amount

18. If claim has been filed with your carrier, what action has your insurer taken or proposes 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
Authority to File Claim

This form is used to document the fact that the officer or agent signing the Standard Form 95 is authorized to act on behalf of the company or corporation filing the claim. This form may not be signed by the person signing the Standard Form 95.

Date: __________

The undersigned is ________________________________________________

(Position: i.e., President, Secretary, etc.)

of _____________________________________________________________

(Name and address of corporation or company)

and in such capacity has access to the books and records of

_______________________________________________________________

(Name of corporation or company)

_______________________________________________________________ is ___________________________________________

(Name of Agent signing claim) (Position of Agent)

(Name of corporation or company)

_______________________________________________________________ and has the power and authority
to file, adjust and settle claims for and on behalf of ________________________________

_______________________________________________________________ as its duly authorized agent.

_______________________________________________________________

Signature*

* This form must be signed by someone other than the person signing the Standard Form 95.

For subrogation: This form should not be signed by your insured.
Attorney Authorization

I, ____________________________, hereby designate and authorize the law offices of ____________________________ to represent me in place and stead, and continue any and all claims which have been filed or will be filed arising from: ____________________________,

which occurred on ____________________________.

Executed on this ______ day of ____________________________, 20____, at ____________________________.

________________________________________
Signature of Claimant
Authorization for Insurance Company to Include Deductible in Subrogation Claims

To: Office of the Judge Advocate General
Tort Claims Unit Norfolk
9620 Maryland Avenue, Suite 100
Norfolk, VA 23511-2989

I, ____________________________, hereby authorize my insurance

(Name of Insured)

company __________________________ to act as my agent in

(Name of Insurance Company)

recovery of my insurance deductible of $______________, incurred as the
result of an incident that occurred on or about ____________________.

(Date of Incident)

Insurance company's claim number: __________________________

__________________         ____________________
Signature of Insured          Date signed

* This form is required for all FTCA and MCA claims when the Standard form 95 is signed by the insurance company "as subrogee and agent" of the insured.