

<u>OFFICE USE ONLY</u>
Claim No. _____

New Jersey Department of Environmental Protection
Climate and Environmental Management
Solid and Hazardous Waste Management Program

SANITARY LANDFILL FACILITY CLOSURE AND CONTINGENCY FUND ACT
N.J.S.A. 13:1E-100 et seq and N.J.A.C. 7:11

DAMAGE CLAIM

PLEASE NOTE: *The filing of this claim form should not be construed as entitling the claimant to receive compensation. The Department must conduct a complete review of the claim prior to any determination regarding compensability.*

SECTION A: GENERAL INFORMATION AND INSTRUCTIONS

1. This claim must be based on actual and verifiable damages proximately resulting from the improper operation or improper closure of a sanitary landfill. The claimant is responsible to read and understand the Act and rules noted above prior to filing a claim.
2. The claim must be filed on this official form not later than one year after the date of discovery of the damages.
3. The claim shall be mailed by certified mail return receipt requested, or delivered by hand to:
 - a. Mail Code 401-02C
New Jersey Department of Environmental Protection
Climate and Environmental Management
Solid and Hazardous Waste Management Program
Financial Management Unit
401 East State Street, 2nd Floor West
P.O. Box 420
Trenton, New Jersey 08625-0420
(609) 292-9880
 - b. the owner and/or operator of the sanitary landfill and/or
 - c. any other responsible persons the claimant alleges to have caused the damage.
4. The claim shall be signed by the claimant. Where the claimant is a minor or incompetent, as defined under New Jersey Law, or is deceased, the claim may be signed by the claimant's parent, guardian, executor, or court-appointed representative, as the case requires.
5. Pursuant to N.J.A.C. 7:11-2.1, no claim by a subrogee or assignee may be filed with or processed by the Department.
6. Since the claim may be denied, or only a portion thereof may be compensated, the claimant may wish to file a civil action in an appropriate court to preserve his legal rights in this matter due to statutes of limitations and other restrictions provided by law.
7. All information must be typewritten or printed legible in black ink. Each question or section must be completed in full or marked as not applicable. Responses requiring additional space may be continued on a separate piece of 8 1/2 x 11 paper. Information on supplemental sheets of paper should be positively identifiable, using the appropriate form section letters and question numbers.
8. Copies of all requested and applicable documents, if obtainable, must be attached to this claim. If unobtainable at this time, they must be submitted within the time period determined by the DEP. All documents submitted with this claim will be retained by the DEP and may be used in subsequent subrogation actions.
9. All damages must be stated in their entirety in a single claim. Provide any other information on the losses which the claimant considers pertinent to the processing of the claim.

SECTION B: PRIORITY

1. Should your claim be granted priority in payment? Yes No
2. State in writing the specific reasons why your claim should be accorded priority: _____

SECTION C: BACKGROUND INFORMATION

- 1. _____
Claimant's Last Name First Middle

- 2. _____
Date of Birth Social Security Number (for payment purposes)

- 3. Claimant is: _____ individual _____ unit of local government _____ individual business
 _____ partnership _____ unit of state government
 _____ corporation

If a partnership, corporation or state agency, provide full legal name, state of principal office, and Federal I.D. No.

- 4. Claimant's Permanent Address: _____
a. Phone Number: (Day) _____ (Evenings) _____

- 5. Claimant's Mailing Address (If different than Permanent Address)

- 6. a. If claimant is a partnership, list the name and address of general partners on a separate sheet and attach hereto. If claimant is a corporation, list name and address of directors and principal officers and state of incorporation on a separate sheet and attach hereto. If claimant is a foreign corporation, is it registered with the N.J. Secretary of State to do business in New Jersey? _____ Yes _____ No

- b. This claim is based on damages proximately resulting from the operations or closure of a sanitary landfill. Check the type of losses for which the claimant is seeking reimbursement from the fund.
 _____ Real Property _____ Business Income _____ Loss of Life
 _____ Personal Property _____ Personal Income _____ Other (Specify)
 _____ Natural Resource(s) _____ Person Injury or Illness _____

- 7. If the claim is prepared and signed by someone other than the claimant pursuant to N.J.A.C. 7:11-1.7(a)5, provide:

- a. _____ c. _____
Name Relationship of Claimant

- b. _____ d. _____
Title Address

- e. _____
Phone

- 8. Location at which the damage occurred.

_____ _____
Municipality Location of the Occurrence (include accurate street address and the exact lot and block numbers)

9. Set forth in detail: (a) When the damages for which this claim is filed occurred, (b) When and how you first discovered these damages, and (c) When and how you discovered their connection to the landfill facility. (Specify date or period of time.) Attach explanation if necessary.

10. Describe the circumstances under which the losses occurred and how they were discovered. If a diagram or map will assist your explanation, please provide same as an attachment.

11. Did you know of the existence of the sanitary landfill facility and did not know, nor reasonably could have known, of the potential that property value diminution could result by virtue of purchasing the property near the particular sanitary landfill facility in question? Yes No

12. If you are claiming for property value diminution, are you attempting to sell the subject property? Yes No

13. If the claimant is a limited partnership, list the names and addresses of all general partners.

14. If the claimant is a general partnership, list the names and addresses of all partners.

15. If the claimant is a corporation, list the names and addresses of all directors and of all officers.

16. Indicate any other information which the claimant believes to be relevant to the claim.

17. Indicate any other information which the Department deems necessary to process the claim.

SECTION D: LIABILITY

1. Set forth the name, address, municipality and county of the sanitary landfill you claim to be responsible for the loss. Also list the names and addresses of the owner/operators, if known. (If owner/operator is unknown include any information that might assist in their identification and location.)

2. Describe in detail the basis upon which it is believed that the sanitary landfill listed above is responsible for any losses you may have suffered.

3. Has anyone admitted liability for any of the losses set forth by you in this claim? If so, please indicate when, where, by whom, in what amount, and, if in writing, attach a copy.

4. Have you received or agreed to receive money, or brought suit or made claim against any fund, person or insurance company, for any losses mentioned in this claim or connected in any way to the losses incurred as a result of the operation or closure of the responsible landfill? If so, provide details and documentation.

5. Set forth the name and address of any other party you feel is responsible for the damage.

SECTION E: PROPERTY LOSSES (Personal and Real)

If no property loss is claimed, check here _____

"Personal Property" means everything that is the subject of ownership except for real property as herein defined.

"Real Property" means land, all rights to and interests in land, and those things, such as buildings and other improvements, which are more or less permanently attached to the land.

Provide below all your real and personal property losses. (If different types of real or personal property were damaged, please make copies of this section of the form and submit as attachments.)

1. Date(s) of damage (Explain) _____

2. Location of property at time of damage _____

3. Description of property which was damaged _____

4. Description of damage _____

5. Original cost of damaged property (Itemize) _____

Include sales agreement and settlement sheet.

6. Date damaged property was acquired by claimant _____

(Attach copy of deed, sale slip, lease, certificate of title, bill of sale, or other documentation, as applicable, evidencing ownership.)

7. Value of property at time of damage (Itemize) _____

8. Estimate or appraisal of total damage to property \$ _____

(For multiple articles of personal property, attach a schedule.)

9. Estimate or appraisal made by _____ whose address and title is

(Name)

10. Present location of the damaged property and time when it may be inspected.

11. Has the damage been repaired? Yes No If "Yes", indicate the name and address of repairer, date and cost of repairs.

12. Attach each estimate or appraisal of damages or bill for repair costs to this form.

13. Description of the use of the damaged real property (residential commercial, etc.) by you before and after your losses occurred.

14. State the name and address of every person or company who has a legal interest or claim in the property for which this claim is made. Describe the nature of this interest, such as mortgage, legal title, etc. Attach evidence of such interest or claim.

15. Describe in detail any other claim you have due to property losses resulting from the operation or closure of the sanitary landfill which you have not yet listed or described in this section.

16. Did you file a claim against the sanitary landfill facility's Environmental Impairment Liability Fund established pursuant to N.J.S.A. 13:1E-109? Yes No

17. Provide a detailed description of the facts known to the claimant which support the claim, such as facts which lead you to believe that the improper operation or improper closure of the sanitary landfill facility caused the damages suffered by you.

18. State the names and addresses of any witnesses known who may have knowledge concerning the improper operation or improper closure, threatened damage, or damaged caused by the sanitary landfill facility.

19. State the names of any public agencies (including, without limitation, any local or state police or any other local, county, state, interstate or federal agencies) who have investigated the improper operation or improper closure activities and, if known to the claimant, the names of the persons who conducted the investigations on behalf of such agencies.

SECTION F: LOSS OF BUSINESS INCOME

If no loss of business income is claimed, check here _____ .

1. Set forth the total amount of business income loss claimed; describe in detail how this loss was calculated.

2. Set forth the period of time for which you have claimed a loss. _____

3. Specifically indicate how much loss is claimed for each calendar quarter commencing with the date of the damage/ occurrence.

4. Describe in detail the precise manner in which you have calculated the amount of lost income.

5. Attach copies of tax returns for the three year period just prior to the commencement of loss for which this claim is filed. Attach sales and/or other fiscal documentation, for inspection and audit, which is the basis, in part or in whole, or your claimed loss of income.
6. Has any income, sales and other accounting or financial information on the basis of which, in part or whole, you have claimed loss of income been audited? Yes No

If "Yes", give name and address of auditor, date of audit and attach copies of relevant audited statements.

7. Describe in detail any other claim you have due to loss of business income resulting from the operation or closure of the sanitary landfill which has not yet been listed or described in this section.

SECTION G: PERSONAL INJURY OR ILLNESS

If no personal injury is claimed, check here _____ .

Complete this section if claiming personal injury or illness.

1. Describe in detail all illnesses or injuries for which this claim is made.

2. Is the injury or illness considered to be permanent? Yes No
3. Set forth in detail a description of all symptoms and diagnoses concerning your injuries or illness of which you are aware, and when you first became aware of the symptoms. Also, describe the extent and personal effect of your injuries or illnesses.

4. For each hospital or facility, doctor or practitioner who has provided you with treatment, examination or diagnostic services for the injury or illness which is the subject of this claim, provide the following information:

a. Name and address of doctor or practitioner, hospital, or other facility

b. Date(s) of treatment or service _____

c. Amount of charges to date _____

d. Amount paid or payable by other sources as insurance _____

e. Attach all written reports prepared by any doctors, hospitals, etc., which describe your illness, injury or any treatment received.

5. Is the claimant eligible to receive any other payments or compensation for the injuries or losses for which this claim is made; including those from insurance companies, government agencies, and any other persons?

____ Yes ____ No

If "Yes", continue to complete the remaining portions of this question, setting forth all benefits received for the injuries or losses claimed.

	<u>Name and Address of Insurance or Government Agency</u>	<u>Insurance Policy No. or other ID Number</u>	<u>Amount of Benefits Rec'd</u>
a. Blue Cross	_____	_____	_____
b. Blue Shield	_____	_____	_____
c. Workmen's Compensation	_____	_____	_____
d. Disability Benefits	_____	_____	_____
e. Welfare	_____	_____	_____
f. Unemployment	_____	_____	_____
g. Medicare	_____	_____	_____
h. Medicaid	_____	_____	_____
i. Major Medical Policies	_____	_____	_____
j. Accident and Health Policies	_____	_____	_____
k. Union or Fraternal Death Benefits	_____	_____	_____
l. Other	_____	_____	_____

m. Social Security No. _____ or Railroad Retirement No. _____

n. Veterans Administration No. _____

o. Life Insurance _____
(Name of Company) (Policy No.) (Amount)

p. Pensions _____
(Name of Company)

6. a. If loss of wages or income of any sort as a result of the injury or illness is claimed, state:

Name of Employer Address of Employer

Claimant's Occupation Dates Employed

Rate of Pay or Salary Dates of Absence from work due to injury or illness

Total Loss of Wages to Date If still out of work, Expected Date of Return

b. Have you been or will you be compensated for the loss of wages/income by your employer or any other insurance program? ___ Yes ___ No If "Yes", explain to what extent.

c. Describe in detail any other claim you have due to injury or illness resulting from the operation or closure of a sanitary landfill not yet listed or described in this section.

SECTION H: INSURANCE / THIRD PARTY COVERAGE

1. State the name and address of the insurance carrier which issued your insurance policy which may provide coverage for any of the damaged real or personal property or any asserted lost income.

2. State the name and address of the insurance carrier which issued the policy, or issuer of the other financial agreement or instrument.

3. Give the policy number or other applicable reference number _____

4. Provide the name and address of any persons other than the fund against whom you asserted a claim.

5. Have you received or agreed to receive any compensation from any person in connection with the damages claimed?
___ Yes ___ No

If "Yes", give details of any such compensation or agreement to receive compensation.

6. Provide a description of any action taken to repair, restore or replace damaged real or personal property including, without limitation, the following:
- a. The name and address of the person who has taken such action

 - b. The cost of such action _____
7. If the claimant asserts any personal injury damages including medical expenses incurred and income lost as a result thereof, the claim shall include the following information:
- a. The total amount of the claimed loss of income
 - b. The period of time during which the claimant asserts that the loss of income has occurred
 - c. If the claimant asserts that the loss of income has occurred over a period exceeding 12 months, a breakdown of the loss of income by three-month periods, with the first such period commencing on the date of discovery
 - d. A detailed description of the method employed by the claimant in calculating the claimed loss of income
 - e. A statement of whether all income, sales and other accounting and financial information supporting the claim is available for inspection, copying and audit by the Department
 - f. If any of the information described in (e) above, is not available for inspection, copying and audit, an explanation of why such information is unavailable for such purposes
 - g. With respect to any of other information described in (e) above, which is available for inspection, copying and audit, a description of where and when the Department can obtain access to such information
 - h. If any of the information described in (a) through (g) above has been audited, certified or reviewed by a certified public accountant, the name, address, and telephone number of such accountant, and the date of such audit, certification or review. If such information has been audited, the claimant shall attach copies of all audited statements and the auditor's reports
 - i. A specific statement as to the nature of the health injuries and how the health injuries are related to the improper operation or improper closure of the sanitary landfill facility in question
 - j. Detailed records substantiating the personal injuries; effects or damaged suffered by the claimant including any medical records, prognosis statements, and documentation indicating the monetary value of medical attention

SECTION I: LOSS OF LIFE

If no loss of life is claimed, check here _____ .

- 1. Attach a copy of the claimant's death certificate.
- 2. Has a will been probated or letters of administration granted? ___ Yes ___ No
- 3. Give name and address of executor or administrator.

- 4. Give name and address of attorney for estate.

5. List spouse, children or other persons dependent for his or her principal support upon the deceased.

<u>Full Name and Address</u>	<u>Date of Birth</u>	<u>Relationship to Deceased</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. State deceased's earnings for the last three years immediately preceding his/her death _____

7. Itemize out of pocket costs of medical, hospital, funeral or other services, giving amount and name and address of person paid or to be paid in each case.

8. Set forth particulars of any other sums received by dependent(s) or claimed to be due as a result of the damages leading to loss of life.

9. Is any dependent identified in Question 5 eligible for any pension or Social Security benefits as a result of the death of the claimant? ____ Yes ____ No

If "Yes", indicate the name of the dependent(s) and whether a claim has been filed for such pension or social security benefits.

10. Provide any other information which you believe is pertinent to the claim.

SECTION J: WITNESSES

1. State the name and address of witnesses or other persons having personal and relevant knowledge of your injury or losses for which this claim is made, and also those with knowledge of the casual relationship between the operations and closure of the landfill and the injuries or losses stated in this claim.

2. State the names of any public agencies (local or state police and other local, state or federal agencies) who have investigated any of the matters involved in this claim.

STATE OF NEW JERSEY
 COUNTY OF _____ SS:

_____ of full age, being duly sworn on his oath or affirmation
 (Name of Affiant)
 according to law deposes and says:

I certify that the foregoing statements made by me in this Claim Application are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Date: _____

 Print Name of Claimant or Claimant's Representative
 authorized pursuant to N.J.A.C. 7:11-1.7

 Signature of Claimant
 or

 Signature of Claimant's Representative authorized
 pursuant to N.J.A.C. 7:11-1.7

Sworn to and subscribed before me this
 _____ day of _____, 20____.

 Notary Public or Attorney at Law