University of Kentucky
Office of Legal Counsel
301 Main Building
Lexington, KY 40506-0032
(859)323-7237
www.uky.edu/legal

University of Kentucky Claim Form
(ONLY FOR CLAIMS LESS THAN $250.00)

Please provide all the facts, statements by witnesses (in writing), or any other proof you have that you believe would be helpful in the determination of your loss/claim. **The burden of proof that the University was negligent rests with you. FOR THE CONSIDERATION OF CLAIMS OVER $50, YOU MUST PROVIDE A PROOF OF PURCHASE OR A RECEIPT. IF THE CLAIM AMOUNT IS MORE THAN $250, YOU MUST FILE WITH THE KENTUCKY BOARD OF CLAIMS.**

Please complete **ALL** sections of this form and submit via email by clicking the submit button at the end of the form or print and return by mail to the below address or scan to boc250@uky.edu:

University of Kentucky
Office of Legal Counsel
301 Main Building
Lexington, KY 40506-0032

CLAIMANT'S FULL NAME (FIRST AND LAST NAME) TYPE OR PRINT

CLAIMANT'S STREET ADDRESS (INCLUDE APT# OR UNIT #)

CITY, STATE, AND ZIP CODE

EMAIL (**WE MUST HAVE AN EMAIL**)

PHONE NUMBER

NAME OF UNIVERSITY OF KY EMPLOYEE INVOLVED IN THE INCIDENT

DATE INCIDENT OCCURRED (MUST BE WITHIN ONE YEAR)

TIME INCIDENT OCCURED

WHERE DID THE INCIDENT OCCUR? (GIVE **EXACT** LOCATION THAT APPLIES INCLUDING CITY, COUNTY, DIRECTION, BUILDING, ROOM NUMBER, MILE MARKER, INTERSECTION, ETC. **PLEASE BE SPECIFIC**

BELOW DESCRIBE THE INCIDENT AND THE DAMAGE DONE TO YOU OR YOUR PROPERTY:

BELOW DESCRIBE HOW YOU FEEL THE UNIVERSTIY OF KENTUCKY IS AT FAULT:

PLEASE PROVIDE THE SPECIFIC DOLLAR AMOUNT OF YOUR CLAIM. Supply bills, receipts and/or repair estmates, as proof of the cost of damages sustained. Pursuant to **KRS 49.130 Conditions of awards - Reduction of award** this amount will be amended according to the amount that can be recovered from other sources available to the claimant, such as worker's comp, social security, federal, state or private insurance programs designed to supplement income or pay claimant's expenses or damages incurred.

IF YOUR CLAIM IS **OVER $250.00** STOP HERE YOU MUST FILE WITH **THE KENTUCKY BOARD OF CLAIMS**, **(BE ADVISED YOUR CLAIM WILL NOT BE FORWARED TO THE STATE IF IT IS OVER $250.00)**

ENTER DOLLAR AMOUNT OF CLAIM (YOU MUST ENTER AN AMOUNT)

If the claim involves a motor vehicle please proceed to the next field, if not you may skip to the signature field AT THE BOTTOM OF THE PAGE(you must provide your signature, 4 digits of your social, date of claim form and email before submitting the form.

If motor vehicles were involved, please complete the following information:

STATE'S VEHICLE:

STATE VEHICLE TAG NUMBER, if known

FULL NAME OF DRIVER OF STATE VEHICLE, if known

DOES THE OPERATOR OF THE STATE OWNED VEHICLE HAVE A RIDER ON THIER INSURANCE POLICY TO COVER THEM WHILE OPERATING A STATE OWNED VEHICLE, IF SO THE CLAIMANT MUST GO THROUGH THE STATE EMPLOYEE'S INSURANCE.

STATE EMPLOYEE'S PERSONAL INSURANCE RIDER

CLAIMANT'S VEHICLE

THIS CLAIM MUST BE FILED AND SIGNED BY THE REGISTERD OWNER OF THE VEHICLE

FULL NAME OF THE **REGISTERED OWNER** OF THE CLAIMANT'S VEHICLE INVOLVED IN THE INCIDENT

VEHICLE INFORMATION:

YEAR, MAKE, AND MODEL OF THE CLAIMANT'S VEHICLE

CLAIMANT/DRIVER AND PASSENGER INFORMATION:

CLAIMANT/DRIVER FULL NAME (FIRST AND LAST NAME)

CLAIMANT/DRIVER STREET ADDRESS (INCLUDE APT# OR UNIT#)

CLAIMANT/DRIVER CITY, STATE, AND ZIP CODE

PASSENGER FULL NAME (FIRST AND LAST NAME)

PASSENGER STREET ADDRESS (INCLUDE APT# OR UNIT#)

PASSENGER CITY, STATE, AND ZIP CODE

POLICE OR INCIDENT REPORT:

NAME OF LAW ENFORCEMENT OFFICER WHO INVESTIGATED THE INCIDENT

IF POSSIBLE PLEASE SUBMIT A COPY OF THE POLICE REPORT, INCIDENT REPORT OR UNIFORM TRAFFIC REPORT

THIS FORM MUST BE SIGNED:

CLAIMAINT'S SIGNATURE (REQUIRED)

By typing your name in the above box you certify that to the best of your knowledge the provided information is true and accurate.

SIGNATURE OF RESPONSIBLE PARTY ONLY IF CLAIMANT IS A MINOR

By typing your name in the above box you certify that to the best of your knowledge the provided information is true and accurate.

WE MUST HAVE:

LAST 4 DIGITS OF CLAIMANT'S SOCIAL SECURITY NUMBER

WE MUST HAVE AN EMAIL

PHONE NUMBER

STREET ADDRESS

CITY, STATE, ZIP CODE

YOU MUST PROVIDE THE DATE:

DATE FORM COMPLETED (MM/DD/YYYY)

THE UNIVERSITY HAS 30 DAYS TO RESPOND TO CLAIM AFTER IT IS RECEIVED

OPEN IN ADOBE TO FILL OUT AND SUBMIT

click below to submit to email

SUBMIT