SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT
Insurance Division
300 Lakeside Drive
Oakland, CA 94604-2688

CLAIM AGAINST SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS 910 ET SEQ*

*Promptly complete this form and mail to: BART, P.O. Box 12688, Oakland, CA 94604-2688, Attn.: Insurance Division

PLEASE PRINT:

NAME OF CLAIMANT: LAST NAME | FIRST NAME | INIT.

MAILING ADDRESS: STREET | CITY | STATE | ZIP CODE PLUS

TELEPHONE NO.: HOME | BUSINESS

DATE OF INCIDENT/OCCURENCE: MONTH | DAY | YEAR | TIME — A.M. ☐ P.M. ☐

LOCATION/PLACE OF INCIDENT/OCCURENCE:

(Please be specific, i.e., Station, train, escalator, stairway, etc.)

DESCRIPTION OF OCCURRENCE OR INCIDENT:

NATURE OF INJURY, LOSS OR DAMAGE RESULTING FROM THE ABOVE:

CAUSE OF INJURY, OR DAMAGE (State what you believe caused the injury, loss or damage and state the name or names of the public employee or employees causing such injury, loss or damage if known):

AMOUNT CLAIMED AS OF DATE OR PRESENTATION OF CLAIM AND THE ESTIMATED AMOUNT OF FUTURE CLAIM, IF KNOWN: (Include the basis of computation of the amount claimed):

I understand that, by furnishing this form, BARTD is not acknowledging any responsibility for payment of my claim.

(DO NOT DETACH - ALL (3) COPIES ARE TO BE RETURNED TO BART.)

Dated: _____ Signed: _____

*CLAIM MUST BE PRESENTED WITHIN 6 MONTHS OF INCIDENT IN ACCORDANCE WITH GOVERNMENT CODE SECTIONS

FORM 1020 (REV. 2, 7/06)

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