The California State University
OFFICE OF THE CHANCELLOR

CSU CLAIM FORM

IS YOUR CLAIM COMPLETE?

☐	**Include a check or money order for $25 payable to "Trustees of the CSU."**
☐	Complete all sections relating to this claim and sign the form. Please print or type all information.
☐	Attach receipts, bills, estimates, pictures or other documents that back up your claim.

CLAIMANT INFORMATION

LAST NAME	**FIRST NAME**		
TELEPHONE NUMBER	**EMAIL ADDRESS**		
MAILING ADDRESS	**CITY**	**STATE**	**ZIP**
IS THE CLAIMANT UNDER 18 YEARS OF AGE? ☐ **YES** ☐ **NO**	**IF YES, GIVE DATE OF BIRTH:**		

ATTORNEY OR REPRESENTATIVE INFORMATION

LAST NAME	**FIRST NAME**		
TELEPHONE NUMBER	**EMAIL ADDRESS**		
MAILING ADDRESS	**CITY**	**STATE**	**ZIP**

CLAIM INFORMATION

Is your claim for a stale-dated warrant (uncashed check)?		☐ **YES**	☐ **NO**	
CSU Campus that issued the warrant:		If **NO** continue to Next Section		
Dollar amount of warrant:	Date of issue:			
Proceed to Notice and Signature Section				

Date of Incident:			
Was the incident more than six months ago?	☐ **YES**	☐ **NO**	
If **YES**, did you attach a separate sheet with an explanation for the late filing?	☐ **YES**	☐ **NO**	
CSU Campus or CSU employees against whom this claim is filed:	Choose Campus (dropdown)		
Dollar amount of claim:			
If the amount is more than $10,000, indicate the type of civil case:	☐	Limited civil case ($25,000 or less)	
	☐	Non-limited civil case (over $25,000)	
Explain how you calculated the amount:			
Location of the incident (be as specific as possible if referencing a campus location):			

Describe the specific damage or injury (attach additional pages as necessary):
Explain the circumstances that led to the damage or injury (attach additional pages as necessary):
Explain why you believe the CSU is responsible for the damage or injury (attach additional pages as necessary):

Does the claim involve a campus vehicle?	○	**YES**	○	**NO**
If YES, provide the vehicle license number, if known:				

AUTO INSURANCE INFORMATION

Name of Insurance Carrier							
Mailing Address		City		State	Zip		
Policy Number:		Telephone Number:					
Are you the registered owner of the vehicle?			○	**YES**	○	**NO**	
IF NO, state name of owner:							
Has a claim been filed with your insurance carrier, or will it be filed?			○	**YES**	○	**NO**	
Have you received any payment for this damage or injury?			○	**YES**	○	**NO**	
If **YES**, what amount did you receive?							
Amount of deductible, if any:							
Claimant's Driver's License Number?		Vehicle License Number:					
Make of Vehicle:		Model:		Year:			
Vehicle ID Number:							

FOR BODILY INJURY CLAIMS ONLY (PURSUANT TO THE MEDICARE SECONDARY PAYER ACT):

If a claim for bodily injury is being made:			
Date of Birth:		Social Security Number:	

NOTICE AND SIGNATURE

I declare under penalty of perjury under the laws of the State of California that all the information I have provided is true and correct to the best of my information and belief. I further understand that if I have provided information that is false, intentionally incomplete or misleading, I may be charged with a crime punishable by up to one year in state prison and/or a fine up to $10,000 (Penal Code section 72).	
Signature of Claimant or Representative	Date

Mail the original completed form and all attachments with the $25 filing fee or the "CSU Affidavit for Waiver of Filing Fee" request to: CSU Office of the Chancellor, Systemwide Risk Management, 401 Golden Shore, 5th Floor, Long Beach CA 90802-4210. Keep a copy for your records.