SAN FRANCISCO BAY AREA RAPID TRANSIT DISTRICT
Insurance Division
2150 Webster Street
Oakland, CA 94612-3012

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: NUMBER | STREET

CITY | STATE | ZIP CODE PLUS

TELEPHONE NO.: MOBILE | OTHER

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. 5/2021)