

CLAIM FORM

MAR 22 2010

FORM B

(Please Type Or Print)

CITY CLERK'S OFFICE

CLAIM AGAINST City of Lemoore  
(Name of Entity)

Claimant's name: RAY MUKFORD

SS#: \_\_\_\_\_ DOB: 9-21- Gender: Male  Female \_\_\_\_\_

Claimant's address: West Deodar Ln.

Address where notices about claim are to be sent, if different from above: PO. Box 997195  
Sacramento CA 95899

Date of incident/accident: 1-18-10

Date injuries, damages, or losses were discovered: 1-18-10

Location of incident/accident: DRIVEWAY

What did entity or employee do to cause this loss, damage, or injury? Street light pole  
FALL ON CAR  
(Use back of this form or separate sheet if necessary to answer this question in detail.)

What are the names of the entity's employees who caused this injury, damage, or loss (if known)? \_\_\_\_\_

What specific injuries, damages, or losses did claimant receive? DAMAGE TO REAR/TRUNK  
OF CAR  
(Use back of this form or separate sheet if necessary to answer this question in detail.)

What amount of money is claimant seeking or, if the amount is in excess of \$10,000, which is the appropriate court of jurisdiction. Note: If Superior and Municipal Courts are consolidated, you must represent whether it is a "limited civil case" [see Government Code 910(f)] \$ 2699.22

How was this amount calculated (please itemize)? PLEASE SEE THE ATTACHED  
DOCUMENTS  
(Use back of this form or separate sheet if necessary to answer this question in detail.)

Date Signed: 3-18-2010 Signature: Karin Bignay

If signed by representative:  
Representative's Name Karin Bignay Address P.O. Box 997195 Sacramento, CA  
Telephone # 800-827-1520 x 25884 95899  
Relationship to Claimant Mercury Insurance Claims Adjuster

CONNELL

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CLAIMS