



THE STATE
of **ALASKA**
GOVERNOR MIKE DUNLEAVY

Department of Administration

DIVISION OF RISK MANAGEMENT
Tracy Mears, Division Director

550 W 7th Avenue, STE 1210
Anchorage, Alaska 99501-0039
Main: 907.465.2180
Fax: 907.465.3690

INSTRUCTIONS FOR NOTICE OF CLAIM FORM

This form is used to notify the State of Alaska of personal injury or property damage that you believe was caused by the State or its employees. Receipt of this form does not imply acceptance of liability. It is the official method for submitting a claim against the State.

Please complete the form thoroughly to assist our adjusters in evaluating your claim.

- The form must be signed and dated. Unsigned forms will be returned.
- Attach any supporting documentation such as estimates, repair bills, photographs, or other relevant materials.

You may submit the completed form and attachments via email at Riskmanagement@alaska.gov or mail to the address above. Once received, a Risk Management adjuster will contact you within 5 business days. The time required to resolve your claim will depend on its complexity and nature.

If you have questions, please contact the Risk Management office at (907) 465-2180.

Thank you,

A handwritten signature in black ink, appearing to read "May Ramirez-Xiong".
May Ramirez-Xiong
Risk Manager



CHECKLIST FOR NOTICE OF CLAIM FORM

Please ensure the following items are completed and attached as applicable:

Required Items

- Completed and signed Notice of Claim Form
- Claimant contact information (name, mailing address, phone number, email)
- Detailed description of incident, including date, time, and exact location (road/intersection, direction of travel, nearest milepost or landmark)
- Explanation of circumstances and why the State of Alaska should be liable

Supporting Documentation

- Police report or related reports
- Two estimates for repairs
- Photographs of damage and/or scene
- Witness(es) contact information
- Proof of ownership for damaged property (title, registration, receipt)
- Insurance carrier contact information and policy number
- Indicate whether you have filed a claim with your insurance carrier (Yes/No)
- Any correspondence related to the incident (emails, letters)
- Repair services invoices and paid receipts (if available)
- If you received medical care, please request that a medical release form be provided to you

Important Notes:

- Claims must be submitted within two (2) years from the date of the incident.
- Incomplete forms or missing documentation may delay processing.
- Submission of this form does not guarantee payment or acceptance of liability.
- Any person who knowingly submits a false or deceptive claim may be subject to criminal prosecution.



NOTICE OF CLAIM FORM

Against: State of Alaska

Receipt of this form does not imply acceptance of liability. It is the official method for submitting a claim against the State of Alaska.

NOTE: This form must be completed in detail and submitted to Risk Management within **two years** of the date of the incident.

I. PERSON OR PERSONS MAKING CLAIM			
Name:		Telephone: Email Address:	
Home Address	Zip:	Mailing Address	Zip:
II. DATE, TIME, PLACE OF INJURY OR DAMAGE			
Date (MM/DD/YYYY):		Time (AM/PM):	Location:
III. PROPERTY INVOLVED			
Description:		If Vehicle (Year, Make, Model, License No.):	
IV. STATE DEPARTMENT INVOLVED (if known)			
Department / Vehicle Number:		State Employee (if known):	
V. INJURED PERSON(S) (Attach additional pages if needed)			
1) Name:	Age:	2) Name:	Age:
Address:	Phone:	Address:	Phone:
Occupation:	Employer:	Occupation:	Employer:
Location & Activity at Time of Injury:		Location & Activity at Time of Injury:	
How Injury Occurred:		How Injury Occurred:	
VI. AMOUNT CLAIMED (Attach estimates or itemized documentation) Total Amount: \$			
VII. DESCRIPTION OF DAMAGES OR INJURIES (Describe in detail)			
VIII. MANNER OF OCCURRENCE (Explain what happened and why the State of Alaska is liable. Attach additional pages if needed)			
<p>*If alleging an injury, you MUST provide: Date of Birth: SSN:</p>			
IX. WITNESSES (Include passengers, police, doctors, or others with relevant information)			
Name 1.)	Address		Phone
2.)			
X. INSURANCE INFORMATION			
Insurance Carrier Name:		Phone:	
Policy Number:		Email	
Have you filed a claim with your insurance carrier?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNATURE OF CLAIMANT (REQUIRED):			DATE PREPARED:

Any person who knowingly submits a false or deceptive claim may be prosecuted criminally.