

STATE OF WISCONSIN CLAIMS BOARD
CLAIM FORM
(§ 16.007, Wis. Stats)

Submit the signed and notarized original of this form to: State of Wisconsin Claims Board, PO Box 7864, Madison, WI 53707-7864.
Questions? Please call (608) 264-9595.

*Claims Board claims are considered public records under Wisconsin's Public Records Law.
This form and any accompanying documentation may be open to inspection by the public.*

Official Use Only

Claim No: _____ Claimant No: _____

Claimant Information

Name: _____
Mr/Ms, first name, last name

Address: _____
Street address, city, state, zip

Phone: _____ **Email:** _____
Daytime phone and area code (optional)

Agency Information

State Agency Name: _____
The Claims Board does not accept claims against private companies, local, or federal government agencies.

Location of Incident: _____
Location where loss, damage, or injury occurred

Date(s) of Incident: _____

Insurance Information

I have insurance coverage for this injury/damage/loss: ___ Yes ___ No

I have filed a claim with my insurer: ___ Yes ___ No

Insurance Company: _____

Amount of Deductible: \$ _____

Claim Information

Total Dollar Amount Claimed: \$ _____ *Attach documentation/receipts/itemization showing proof of dollar amount claimed. Do not submit original documents, they will not be returned to you. There are statutory restrictions on the amount of money the Claims Board can award, see the Claims Board pamphlet or contact the Claims Board for more information.*

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