

More - Affected
Completed
16-28557

CITY OF NORMAN
POST OFFICE BOX 370
NORMAN, OKLAHOMA 73070

NOTICE OF TORT CLAIM

CLAIMANT: Kendal Galey ^{+ Yvonne} DATE: 8/10/17
ADDRESS: 6450 Belmar Circle CITY: NORMAN
STATE: OK ZIP: 73071 PHONE: (H) 816-6759 (W) 816-6787
DATE OF INCIDENT: 8/15/2016
LOCATION OF INCIDENT: BELMAR CIR / INDIAN HILLS ROAD

STATEMENT OF CIRCUMSTANCES / REASONS YOU BELIEVE CITY IS LIABLE:

A removal Control Unit collided into
side of my vehicle that was driven
by my wife, Yvonne Galey, when making
an improper U-Turn in the neighborhood
front gate as she was approaching the
intersection to turn onto Indian Hills

(use additional pages if necessary)

MONETARY STATEMENT: List of expenses claimed for payment:

Tow \$ 75.00 \$ _____
Rental Car \$ 317.87 \$ _____
Car Repairs \$ 3805.12 \$ _____

TOTAL AMOUNT CLAIMED: \$ 4197.99

NAME AND ADDRESS OF INSURANCE COMPANY: State Farm
AGENT: Brian Sandlin

THIS FORM MUST BE SIGNED AND RETURNED WITH ALL REQUESTED INFORMATION IN ORDER TO BE PROCESSED

I SWEAR AND/OR AFFIRM THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

Kendal Galey
CLAIMANT'S SIGNATURE

FILED IN THE OFFICE
OF THE CITY CLERK
ON 8/10/17

Medical See attached
claim page 2

Moore - Offices
Complex
16-28557

CITY OF NORMAN
POST OFFICE BOX 370
NORMAN, OKLAHOMA 73070

NOTICE OF TORT CLAIM

CLAIMANT: Yvonne Galey DATE: 8/9/17
ADDRESS: 6450 Belmar Circle CITY: NORMAN
STATE: OK ZIP: 73071 PHONE: (H) 816-6787 (W) 816-6759

DATE OF INCIDENT: 8/15/2016

LOCATION OF INCIDENT: Belmar Circle / Indian Hills Road

STATEMENT OF CIRCUMSTANCES / REASONS YOU BELIEVE CITY IS LIABLE:

Animal Control unit collided into the
side of my vehicle, which is titled
in my husband, Kendall Galeys name.
when making an improper U-Turn
into my neighborhood at the front
gate as I was approaching the
intersection to turn onto Indian Hills.
(use additional pages if necessary)

MONETARY STATEMENT: List of expenses claimed for payment:

Emergency Visit \$ 3491.50 Accident & Travel \$ 3443.00
Emergency Dr. \$ 712.00 RX \$ 58.01
Radiology \$ 80.00 Loss Wages \$ 612.00

TOTAL AMOUNT CLAIMED: \$ 8396.51

NAME AND ADDRESS OF INSURANCE COMPANY: State Farm
AGENT: Brian Sandler

THIS FORM MUST BE SIGNED AND RETURNED WITH ALL REQUESTED INFORMATION IN ORDER TO BE PROCESSED

I SWEAR AND/OR AFFIRM THE INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT.

FILED IN THE OFFICE
OF THE CITY CLERK
ON 8/10/17

Yvonne D. Galey
CLAIMANT'S SIGNATURE

RX = \$ 11.99
42.89
.96
2.17

Total RX 58.01