GOVERNMENT CLAIM FORM

Inland Empire Health Plan

Government Tort Claims

If you wish to present a government tort claim against Inland Empire Health Plan ("IEHP") pursuant to the California Government Claims Act (Government Code §§ 900–935.6), your claim must be submitted in writing and delivered or mailed to:

Secretary to the Governing Board
Inland Empire Health Plan
10801 Sixth Street
Rancho Cucamonga, CA 91730

In accordance with Government Code section 915(a), claims must be presented by personal delivery or United States mail to the Secretary to the Governing Board. IEHP does not accept the electronic submission of government tort claims. Claims submitted by email, facsimile, online form, or other electronic means will not be deemed received for purposes of the Government Claims Act.

For questions regarding the claims process, you may contact the Legal Department at legal@iehp.org. Please note that directing inquiries to the Legal Department does not constitute presentation of a claim.

CLAIMANT INFORMATION

Last Name	First Name	M.I.

Telephone Number	Email Address

Mailing Address	City	State	ZIP

NOTICE ADDRESS (if different from above)

Give the address and telephone number to which you desire notices or communications regarding this claim to be sent, if different from your address above (e.g. attorney or authorized representative)

Name	Telephone Number

Mailing Address	City	State	ZIP

CLAIM INFORMATION

Name of IEHP Employee(s) or Department(s) involved, if known:

Date of Incident (mm/dd/yyyy)	Incident Location

Specific Damage or Injury Description (describe the nature and extent of the damage or injury):

_____

_____

_____

Circumstances That Led to Damage or Injury:

_____

_____

_____

GOVERNMENT CLAIM FORM

Inland Empire Health Plan

Inland Empire Health Plan — Government Claim Form (continued)

CLAIM INFORMATION (continued)

Dollar Amount of Claim:

☐ Limited ($25,000 or less) ☐ Non-Limited (over $25,000)

☐ Amount Claimed (required if $10,000 or less)_____

Basis/Computation of Amount Claimed (required if $10,000 or less):

NOTICE AND SIGNATURE

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am the claimant or am authorized to act on the claimant's behalf. I understand that the presentation of a false or fraudulent claim is a violation of California law and may result in criminal penalties.

Signature	Date

Printed Name

Note: Attach copies of any supporting documentation (e.g., medical records, photographs, receipts) with your claim. Do not submit original documents. IEHP is not responsible for original documents submitted with a claim.

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