

CITY OF SEBASTOPOL
CITY COUNCIL
STAFF REPORT

Meeting Date: January 3, 2017
To: Honorable Mayor and City Councilmembers
From: City Manager-City Attorney Larry McLaughlin
Assistant City Manager/City Clerk Mary Gourley
Subject: Rejection of Claim for Money or Damages against the City of Sebastopol Filed by Allstate Insurance on behalf of Nicholle Galvan
Recommendation : That the City Council Approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing
Funding: Currently Budgeted: _____ Yes _____ No XX N/A
Net General Fund Cost:
Amount: \$

INTRODUCTION: This item is to request that the City Council approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing.

BACKGROUND:

A claim was filed against the City of Sebastopol on December 12, 2016.

A copy of the claim is attached for the City Council's information.

DISCUSSION:

City staff and REMIF have reviewed the claim submitted and believe the claim is without merit.

RECOMMENDATION:

Staff recommends that the City Council Approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing

Attachment:

Claim Filed December 12, 2016 (Galvan)

File with:
Office of the City Manager/Assistant
City Manager/City Clerk, MMC
City of Sebastopol
7120 Bodega Avenue
Sebastopol, CA 95472

Received

DEC 12 2016

City of Sebastopol

Date Received:

CLAIM FOR MONEY OR
DAMAGES AGAINST THE
CITY OF SEBASTOPOL

A claim must be presented, as prescribed by the Government Code of the State of California, by the claimant or a person acting on his/her behalf and shall show the following:

If additional space is needed to provide your information, please attach sheets, identifying the paragraph(s) being answered.

1. Name and Address of the Claimant:

Name of Claimant: Allstate Insurance ASO Nicholle Galvan
Address: POB 21169 Roanoke, VA 24018

Mailing Address (if different than above): _____

Telephone Number: 540-725-7075

2. Address to which the person presenting the claim desires notices to be sent:

Name of Addressee: Allstate Insurance - Brooke Law
Mailing Address (if different than above): _____

Telephone Number: 540-725-7075

3. The date, place and other circumstances of the occurrence or transaction which gave rise to the claim asserted.

Date of Occurrence: 8/16/2016 Time of Occurrence: 10:50am
Location: Main Str. and Morris Str.

Circumstances giving rise to this claim:

Police officer pulled car insured over and hit their flashlight against the car 3 times

4. General Description of the indebtedness, obligation, injury, damage or loss incurred so far as it may be known at the time of the presentation of the claim.

Rear Quarter Panel

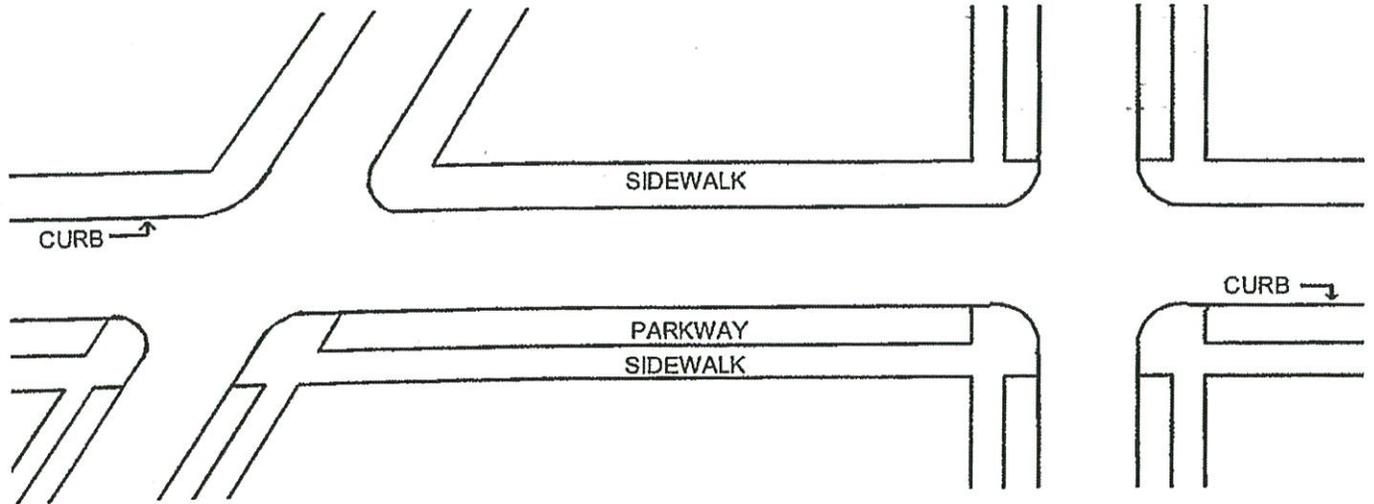
5. The name or names of the public employee or employees causing the injury, damage, or loss, if known.

Sebastopol Police Dept.

READ CAREFULLY

For all accident claims, place on following diagram name of streets, including North, East, South and West; indicate place of accident by "X" and by showing house numbers or distances to street corners. If City/Agency Vehicle was involved, designate by letter "A" location of City/Agency Vehicle when you first saw it, and by "B" location of yourself or your vehicle when you first saw City/Agency Vehicle; location of City/Agency vehicle at time of accident by "A-1" and location of yourself or your vehicle at the time of the accident by "B-1" and the point of impact by "X".

NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.



WARNING: Presentation of a false claim with the intent to defraud is a felony (Penal Code § Pursuant to CCP § 1038, the City/Agency may seek to recover all costs of defense in the event an action is filed which is later determined not to have been brought in good faith and with reasonable cause.

Signature: _____

Brooke Law

Date: _____

12/17/2016

Printed Name: _____

Brooke Law

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6. a. If the amount claimed totals less than \$10,000: The amount claimed if it totals less than ten thousand dollars (\$10,000) as of the date of the presentation of this claim, including the estimated amount of any prospective injury, damage, or loss, insofar as it may be known at the time of the presentation of the claim, together with the basis of computation of the amount claimed.

Amount Claimed and basis for computation:

All estimates attached

b. If the amount claimed exceeds \$10,000: If the amount claimed exceeds ten thousand dollars (\$10,000), no dollar amount shall be included in the claim. However, it shall indicate whether the claim would be a limited civil case. A limited civil case is one where the recovery sought, exclusive of attorney fees, interest and court costs does not exceed \$25,000. An unlimited civil case is one in which the recovery sought is more than \$25,000. (See CCP § 86)

LIMITED CIVIL CASE

UNLIMITED CIVIL CASE

You are required to provide the information requested above, plus your signature on page 3 of this form, in order to comply with Government Code §910. In addition, in order to conduct a timely investigation and possible resolution of your claim, the City requests that you answer the following questions.

7. Claimant(s) Date(s) of Birth:

2/19/1982

8. Name, address and telephone number of any witness(es) to the occurrence or transaction which gave rise to the claim asserted:

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9. If the claim involves medical treatment for a claimed injury, please provide the name, address and telephone number of any doctors or hospitals providing treatment.

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If applicable, please attach any medical bills or reports or similar documents supporting your claim.

10. If the claim relates to an automobile accident:

Claimant (s) Auto Insurance Company: Allstate

Telephone: _____

Address:

POB 21169 ROSHARON, VA 24018

Insurance Policy Number: _____

Insurance Broker/Agent: _____

Telephone: 540-725-7078

Address: _____

Claimant's Vehicle License Number: _____

Vehicle Make/Year: _____

Claimant's Driver License Number: _____

Expiration: _____

If applicable, please attach any repair bills, estimates, or similar documents supporting your claim.



Allstate.
You're in good hands.

Roanoke National Subrogation Claim Cntr
PO BOX 21169
ROANOKE VA 24018



Office of City Manager
City of Sebastopol
1120 Bodega Ave
Sebastopol, CA 95472

September 29, 2016

CLAIM NUMBER: 0424056539 F7E
DATE OF LOSS: August 06, 2016
OUR INSURED: NICHOLLE GALVAN
YOUR FILE NUMBER:
YOUR INSURED:
ADDRESS:

PHONE NUMBER: 800-776-2615
FAX NUMBER:
OFFICE HOURS: Mon - Fri 7:30 am - 6:00 pm

CITY STATE ZIP: , ,
LOSS LOCATION: Main St and Morris St, Sebastopol, , CA
AMOUNT OF LOSS: \$250.00

Re: Subrogation Claim Notice

Dear SEBASTOPOL POLICE DEPARTMENT,

Our investigation indicates your insured was responsible for the loss referenced above.

Please accept this letter as notice of our subrogation claim. Enclosed, you will find copies of the supporting documents for which we are seeking reimbursement. To assist you in your review, the following is a breakdown of our subrogation demand:

Auto Damage (Company Paid):	\$150.00
Rental:	\$
Towing:	\$
Other:	\$
Deductible (Customer Paid):	\$100.00
Salvage Recovery:	\$
Insured Out of Pocket (please send directly to our Insured):	\$

Please forward your payment with our claim number to:

**Allstate Payment Processing Center
P.O. BOX 650271
Dallas, TX 75265 0271**

0424056539 F7E

Be advised that any amounts received from you for less than the amount demanded will be considered an undisputed partial payment amount only, and we retain the right to pursue full payment.

We ask that you direct any future correspondence to the address listed at the top of this letter. Thank you.

Sincerely,

BROOKE LAW

BROOKE LAW
800-776-2615 Ext. 7257078
Allstate Northbrook Indemnity Company

Report Date: 09/29/2016

Payment Ledger

Policy Holder:	NICHOLLE AND ARTURO GALVAN	Total Amount Paid	\$150.00
Participant:	NICHOLLE GALVAN	Medical Deductible:	\$0.00
Date of Loss:	08/06/2016	Co-payment Amount	\$0.00
Claim Number:	0424056539		

Payment/Credit Date	Payee/Payor	Check#		Amount
08/11/2016	NICHOLLE GALVAN	555213570	S	150.00