RETURN TO: CITY OF COUNCIL BLUFFS, IOWA
ATTN: CITY LEGAL DEPARTMENT
OR CITY CLERK
209 PEARL STREET
COUNCL BLUFFS, IA 51503

CITY CLAIM NO. 24-PW-2224

NOTICE OF CLAIM/LOSS

NAME OF CLAIMANT: Jill M. Bach DAY PHONE [redacted]

ADDRESS: [redacted] DOB: [redacted]

DATE & TIME OF LOSS/ACCIDENT: 2/14/24 4pm

LOCATION OF LOSS/ACCIDENT: Southbound lane at 3320 Harry Langdon Blvd, Co Bluffs

DESCRIPTION OF LOSS/ACCIDENT: Driving southbound at ↑ and hit deep pothole, front passenger tire blew out the side wall and ruined tire. See back for more details.

(USE BACK OF FORM, IF NECESSARY)

TOTAL DAMAGES CLAIMED: $ 77.40

WITNESS(ES) (Name(s), Address(es), Phone No(s): [redacted]

WAS POLICE REPORT FILED ____ YES X NO

IF MEDICAL ATTENTION WAS REQUIRED, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NO. OF TREATING PHYSICIAN AND FACILITY:

n/a

HAVE YOU RESUMED NORMAL ACTIVITIES? X YES ____ NO

IF YOU INCURRED PROPERTY DAMAGE, PLEASE DESCRIBE AND PROVIDE COPIES OF ESTIMATES, INVOICES, PHOTOGRAPHS, AND ANY OTHER RELEVANT INFORMATION: photos included

LIST INSURANCE PROVIDER AND COVERAGE: [redacted] (did not file claim)

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IN SUPPORT OF MY CLAIM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

NOTE: IT IS A FRAUDULENT PRACTICE PUNISHABLE BY FINE OR IMPRISONMENT TO KNOWINGLY MAKE A FALSE CLAIM (SECTION 714.8(3) CODE OF IOWA)

2/28/24
DATE

Jill Bach
CLAIMANT'S SIGNATURE

CLERK RCVD

RECEIVED
MAR 05 2024
CITY ATTORNEY'S OFFICE

5 MAR'24

AM 11:38

RETURN TO: CITY OF COUNCIL BLUFFS, IOWA
ATTN: CITY LEGAL DEPARTMENT
OR CITY CLERK
209 PEARL STREET
COUNCL BLUFFS, IA 51503

CITY CLAIM NO. 24-PW-2225

NOTICE OF CLAIM/LOSS

NAME OF CLAIMANT: Walter J "Bud" Kilnoski DAY PHONE: [redacted]

ADDRESS: [redacted] DOB: [redacted]

DATE & TIME OF LOSS/ACCIDENT: January Snow Storm 2024.

LOCATION OF LOSS/ACCIDENT: South Street Level Retaining Wall

DESCRIPTION OF LOSS/ACCIDENT: Several Blocks Damaged at Street Level See Photos

(USE BACK OF FORM, IF NECESSARY)

TOTAL DAMAGES CLAIMED: $ +/- 4,000.00 / per Weilage Landscaping

WITNESS(ES) (Name(s), Address(es), Phone No(s).: [redacted]

WAS POLICE REPORT FILED ____ YES X NO

IF MEDICAL ATTENTION WAS REQUIRED, PLEASE PROVIDE NAME, ADDRESS, AND TELEPHONE NO. OF TREATING PHYSICIAN AND FACILITY:

HAVE YOU RESUMED NORMAL ACTIVITIES? | YES ____ NO

IF YOU INCURRED PROPERTY DAMAGE, PLEASE DESCRIBE AND PROVIDE COPIES OF ESTIMATES, INVOICES, PHOTOGRAPHS, AND ANY OTHER RELEVANT INFORMATION:

CLERK RCVD

LIST INSURANCE PROVIDER AND COVERAGE:

5 MAR '24 AM 11:38

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2/29/24
DATE

RECEIVED
MAR 05 2024
CITY ATTORNEY'S OFFICE

Walter Kilnoski
CLAIMANT'S SIGNATURE