KING COUNTY
FLOOD CONTROL DISTRICT

King County Courthouse
516 Third Avenue
Room 1200
Seattle, WA 98104

Signature Report

FCD Resolution FCD2026-07

Proposed No. FCD2026-07.1 **Sponsors**

A RESOLUTION updating the appointment of the agent to receive claims for damages against the King County Flood Control Zone District under chapter 4.96 RCW; and repealing FCD2011-01.

WHEREAS, chapter 4.96 RCW requires that all claims for damages against a local governmental agency arising out of tortious conduct must be filed with the agency before a civil lawsuit is commenced, and

WHEREAS, RCW 4.96.020 requires the governing body of each local governmental agency to appoint an agent to receive any claim for damages under Chapter 4.96 RCW, and

WHEREAS, in 2009, the Board of Supervisors adopted FCD resolution FCD2009-17.1, appointing the agent to receive claims for damages consistent with applicable law, and

WHEREAS, in 2011, the Board adopted FCD resolution FCD2011-01 to supersede FCD2009-17.1 and update the address for service of any claim for damages, and

WHEREAS, the Board desires to again update the physical location and current mailing address for submission of claims to ensure the public retains an accessible method for submitting claims;

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF SUPERVISORS OF THE KING COUNTY FLOOD CONTROL ZONE DISTRICT:

SECTION 1. The Clerk of the Board of the King County Flood Control Zone District, or the Clerk's successor, is appointed as the agent to receive any claim for damages against the District under chapter 4.96 RCW. The agent may be reached during the hours of 8:30 am to 4:30 p.m., Monday through Friday, except legal holidays, at King County Office of Risk Management Services, 201 S. Jackson Street, Suite 320, Seattle, Washington 98104.

SECTION 2. The Clerk of the Board of the King County Flood Control Zone District is authorized and directed to record a copy of this resolution with the King

County Recorder's Office.

SECTION 3. Resolution FCD2011-01 is herein repealed.

FCD Resolution FCD2026-07 was introduced on 4/1/2026 and passed by the King County Flood Control District on 6/9/2026, by the following vote:

Yes: 9 - Balducci, Barón, Dunn, Dembowski, Fain, Lewis, Mosqueda, Perry and von Reichbauer

KING COUNTY FLOOD CONTROL DISTRICT
KING COUNTY, WASHINGTON

Signed by:
B60CACB4B3EC49E...

Reagan Dunn, Chair

ATTEST:

DocuSigned by:
Russell Pethel
42A7D875B6B4420...

Russell Pethel, Clerk of the District

Attachments: A. King County Flood Control Zone District Claim For Damages Form

INSTRUCTIONS FOR COMPLETING THE CLAIM FOR DAMAGE FORM

Before filing a Claim for Damage please read these instructions and the Claim for Damage form in its entirety.

Type or print clearly in ink and sign the Claim for Damage form. If you are incapacitated, a minor or a non-resident of the state, a relative, attorney or agent may sign on your behalf.

Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

If the requested information cannot be supplied in the space provided, please use additional blank sheets so your claim can be easily read and understood.

Records you submit are subject to public disclosure laws.

The following are examples on how to complete the Claim for Damage form:

(1) Doe, John Conner, 12/01/1910

(2) 222 One Way Street, Apt. Z, Seattle, Washington 98178

(3) Post Office Box 111, Seattle, Washington 98178

(4) Same

(5) (206) 555-5555

(6) 01/01/2009, 8:00 a.m.

(7) If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item (7).

(8) Washington, King, Seattle, My Residence or Business Name

(9) I-5, southbound, Milepost, near XYZ Exit.

(10) King County Flood Control District

(11) If you are represented by an attorney, check the "Yes" box and fill out the information requested. If you are not represented by an attorney, check the "No" box and proceed to section (12).

(12) List all witnesses who have knowledge of the incident in question, with their names, addresses, and telephone numbers. Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.

(13) Please describe the incident that resulted in injury or damage, specifically answering the questions who, what, where, when and why.

(14) If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.

(15) Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include medical records and bills.

(16) Attach documents which support the claim's allegations.

(17) Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss etc. This amount should represent your opinion of total compensation.

(18) If you were injured, please complete the Medicare Verification form (attached).

KING COUNTY FLOOD CONTROL ZONE DISTRICT
CLAIM FOR DAMAGES FORM

Mail, E-mail or Hand Deliver Form to:

For Mail / Hand Delivery: King County Flood Control District – Clerk of the Board
c/o King County Office of Risk Management Services
201 S. Jackson St., Suite 320
Seattle, WA 98104

E-mail: kcc.flood@kingcounty.gov

CLAIMANT INFORMATION

(1) Claimant's Name: _____,
(Last Name) (First) (Middle) (Date of Birth: mm/dd/yyyy)

(2) Current Residential Address: _____,

(3) Mailing Address (if different): _____,

(4) Residential Address for Six Months Prior to the Date of the Incident (if different from current address):

_____

(5) Claimant's Daytime Phone Numbers: Home #_____ Cell #_____

Business #_____ Claimant's Email Address:_____

INCIDENT INFORMATION

(6) Date of Incident: _____ Time: _____ □a.m. □p.m. (check one)
(mm/dd/yyyy)

(7) If the incident occurred over a period of time, date of first and last occurrences:
From: _____ Time: _____ □a.m. □p.m. (check one)
(mm/dd/yyyy)
To: _____ Time: _____ □a.m. □p.m. (check one)
(mm/dd/yyyy)

(8) Location of Incident: _____
(state and county) (city if applicable) (place where occurred)

(9) If the incident occurred on a street or highway: _____
(name of street/highway) (mile post) (at intersection with or nearest intersecting street)

(10) District or agency alleged responsible for damage/injury:_____

(11) Are you represented by an attorney? ☐ Yes ☐ No

Attorney name: _____

Mailing address: _____
Street Address City State Zip

Email Address: _____

Phone: _____

(12) Name, addresses, and telephone numbers of all individuals involved in or witnesses to this incident, or knowledge of the claimant's resulting damage. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.

_____

_____

(13) Describe the cause of the injury or damage. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.

_____

_____

(14) Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?

_____

_____

(15) Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.

_____

_____

(16) Please attach documents which support the claim's allegations.

(17) I am claiming damages in the amount of $_____

(18) If you are injured, are you a Medicare beneficiary? □Yes □No (check one) If Yes, please complete the Medicare Verification form.

****ADDITIONAL INFORMATION REQUIRED FOR AUTOMOBILE CLAIMS ONLY****

License Plate # _____ Driver License # _____

Type Auto: _____
(year) (make) (model)

DRIVER:	_____	**OWNER:**	_____
Address:	_____	Address:	_____
			_____
Phone #:	_____	Phone #:	_____
PASSENGERS:			
Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____

The claimant must sign this claim form unless he or she is incapacitated, a minor, or a nonresident of the state, in which case it may be signed on behalf of the claimant by any relative, attorney, or agent representing the claimant.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

I, _____, being first duly sworn, depose and say that I am the claimant for the above described; that I have read the above claim, know the contents thereof and believe the same to be true.

X _____

X _____
Signature of Claimant(s)

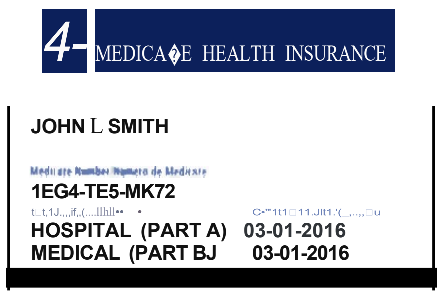
Medicare Verification Form

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)** / /	
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex** o Female	☐Male

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Medicare Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) **Medicare Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form **Date**