Date

Responsible Party First and Last Name

Responsible Party Mailing Address

Responsible Party City, State Zip Code

 **CERTIFIED, RETURN RECEIPT REQUESTED**

RE: ***CITY OF RESTITUTION DEMAND THIRD REQUEST***

DATE OF LOSS: Month/Day/Year

 LOSS LOCATION: Specific Address

 DAMAGES: What was damaged

 CITY FILE NUMBER: Reference number

Dear Mr., Mrs., or Ms. Responsible Party Last Name:

On the above captioned date, *explain what caused the accident*, causing damage to the City’s property. The City sustained damage in the amount of $\_\_\_\_\_\_\_\_\_\_ to their property.

We have attempted to contact you several times in regard to your responsibility for city-owned damaged property, without the courtesy of a reply. If you fail to respond to us within the next 30 days, we will take further action. Unpaid damages may result in a legal judgment against you, the loss of your driving privileges, including the suspension of your California vehicle license plate number ADD LICENSE PLATE NUMBER.

Should you have any questions, please contact the undersigned immediately to avoid further action against you.

Thank you for your attention and cooperation.

Sincerely:

Name

Title

Enclosure

Cc: City Officer, City Officer’s Title, Name of City (without enclosure)

Responsible Party First and Last Name

Claim Number

Your Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number of your insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The name on the policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your agent’s name and phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you reported this loss to your insurance company?

Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

If yes, what claim number has your insurance company assigned to the claim

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am willing to make payments to the City in the amount of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on a

monthly basis until my debt is satisfied.

Please return this form to: Your Name

 Address

 City, CA Zip Code

Thank you for your cooperation.