TORT CLAIM PAYMENT REPORT

For use of this form see DA PAM 27-162; the proponent agency is OTJAG.

A SEPARATE PAYMENT REPORT MUST BE COMPLETED FOR EACH CLAIMANT

1. TO: DFAS, DSSN	2. DATE *(YYYYMMDD)*

SECTION A - PAYMENT DATA

3. SUBMITTING AGENCY/OFFICE		4. OFFICE CODE
5. AGENCY/OFFICE MAILING ADDRESS		6. DATE CLAIM FILED *(YYYYMMDD)*
7. CLAIM NUMBER(S)	8. AMOUNT CLAIMED	9. FUND CITE
10. PAYEE	11. ADDRESS	
12. SSN OR TAX IDENTIFICATION NUMBER	13. PAYMENT AMOUNT	14. TYPE OF PAYMENT

FOR EFT PAYMENTS

15. ABA ROUTING NUMBER	16. ACCOUNT NAME AND NUMBER
17. NAME AND ADDRESS OF FINANCIAL INSTITUTION	18. ACCOUNT *(Check appropriate account)* ☐ CHECKING ☐ SAVINGS

SECTION B - ACCEPTANCE BY CLAIMANT

(This form should not be signed by the claimant if another release is signed by the claimant and attached)

I, the claimant, do hereby accept the within-stated award, compromise, or settlement as final and conclusive on my heirs, executors, administrators or assigns, and agree that said acceptance constitutes a complete release by me, my heirs, executors, administrators or assigns of any and all claims, demands, rights, and causes of action of whatsoever kind and nature, arising now or in the future from, and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries (including wrongful death), damages to property, breaches of contract or law, and any other acts or omissions, and the consequences therefrom resulting, and to result, from the same subject matter that gave rise to the claim for which I or my heirs, executors, administrators, or assigns, and each of them, now have or may hereafter acquire against the United States and against the employee(s) of the Government whose acts or omissions gave rise to the claim by reason of the same subject matter. I further agree to reimburse, indemnify and hold harmless the United States, its agents, servants and employees from any and all claims or causes of action, including wrongful deaths, that arise or may arise from the acts or omissions that gave rise to the claim(s) by reason of the same subject matter.

19. SIGNATURE OF CLAIMANT	20. DATE *(YYYYMMDD)*

SECTION C - AGENCY CERTIFYING OFFICER

Pursuant to authority vested in me, I certify that this Payment Report is correct and proper for payment.

21. SIGNATURE OF AUTHORIZED CERTIFYING OFFICER	22. DATE *(YYYYMMDD)*
23. TITLE	24. DATE PAYMENT RECORDED IN CLAIM RECORD *(YYYYMMDD)*