

# ARKANSAS CLAIMS COMMISSION

D.02

(501)682-1619  
(501)682-2823 FAX



101 EAST CAPITOL AVENUE, SUITE 410  
LITTLE ROCK, ARKANSAS 72201-3823

## CLAIM FORM

Please note that all sections must be completed, or this form will be returned to you, which will delay the processing of your claim.

**1. Claimant** *(If there are additional claimants, please fill out an additional form for each)*

Sigel Benjamin

(title/last name/first name or company)

(email)

(address)

(city)

(state)

(zip)

(primary phone)

**2. Claimant's Legal Counsel** *(If not represented by an attorney, you may skip this section)*

(last name)

(first name)

(email)

(address)

(city)

(state)

(zip)

(primary phone)

Arkansas Bar Number:

*If not licensed to practice law in Arkansas, please  
contact the Claims Commission for more information.*

**3. State Agency Involved** University of Arkansas for Medical Sciences

*(If this section is not completed, the claim will be returned to you as deficient. Please note that the agency or agencies involved must be state agencies. The Claims Commission has no jurisdiction over claims against counties, cities, school districts, or other municipalities.)*

**4. Incident Date** 6/30/2019

**5. Claim Type**

Salary Due

**5a. Location of Incident**

**5b. Explanation of Incident**

Term vacation payout that was due in prior fiscal year.

5c. CHECK HERE if this claim involves damage to a motor vehicle. ☐

5d. CHECK HERE if this claim involves damage to property other than a motor vehicle. ☐

**5e. Insurance Coverage**

- If your property was covered by insurance on the date of the incident, you must provide a copy of the insurance declarations in effect at that time. This is not the same as your insurance card. You may obtain a copy of your insurance declarations from your insurer or insurance agent.

-If you did NOT have insurance coverage in effect on your property on the date of the incident, CHECK HERE ☐

**5f. Additional Required Documents for Property Damage Claims**

You must submit invoice(s) documenting repair costs OR three estimates for repair OR an explanation why this documentation cannot be provided.

**6. If a state vehicle was involved, please provide the following information**

---

(type of state vehicle involved)

(license number)

(driver)

**7. If your claim involves personal injuries, please CHECK HERE ☐**

- All personal injury claims require a copy of your health insurance information in place at the time of the incident.

- If you did NOT have health insurance on the date of the incident, CHECK HERE ☐

**8. Amount Sought:** \$16,154.40

**IMPORTANT**

Please note that the Claims Commision staff is happy to answer questions about the claim process, but Claims Commission staff cannot give legal advice. For questions please contact us through email at [ascc.new.claims@arkansas.gov](mailto:ascc.new.claims@arkansas.gov) or by phone at (501) 682-1619.

# ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619  
FAX (501) 682-2823



KATHRYN IRBY  
DIRECTOR

101 EAST CAPITOL AVENUE  
SUITE 410  
LITTLE ROCK, ARKANSAS  
72201-3823

## CLAIM SUBMISSION SIGNATURE PAGE

The undersigned certifies that to the best of my knowledge, information, and belief, this claim is not being presented for any improper purpose; this claim is warranted by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law or for establishing new law; and the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery.

Benjamin A. Sigel  
Claimant Name (must be printed legibly)

B. Sigel  
Claimant Signature

### Acknowledgement

State of Arkansas

County of Pulaski

On this the 7<sup>th</sup> day of August, 2023, before me, the undersigned notary, personally appeared Benjamin A. Sigel known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Therese M. Cheatham  
Signature of Notary Public

My Commission expires: 06/23/2025



[Seal of Office]



**Sherri L. Robinson**  
Sr. Associate General Counsel  
Tel.: 501-686-7964  
Fax: 501-686-7736

**Office of General Counsel**  
4301 West Markham Street, #860  
Little Rock, AR 72205-7199  
[SLRobinson@uams.edu](mailto:SLRobinson@uams.edu)

August 8, 2023

Kathryn Irby, Director  
Arkansas State Claims Commission  
101 East Capitol, Suite 410  
Little Rock, AR 72201-2823

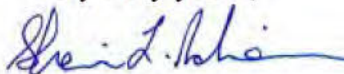
RE: Employee: Benjamin Sigel  
Employee ID: [REDACTED]  
Fund: CCA  
Appropriation: 429  
Agency Number: 150

Dear Ms. Irby:

Enclosed is a claim for the underpaid salary against UAMS. UAMS wishes to consent to the award of \$16,154.40 in this claim, which should be paid from current fiscal year funding. Please advise if there are any further pleadings which need to be filed.

Let me know if you have any questions.

Very truly yours,

  
Sherri L. Robinson

SLR:svm  
Enclosures



**August 7, 2023**

**Arkansas Claims Commission  
101 E. Capitol Ave., Suite 410  
Little Rock, AR 72201**

**RE: Uncontested Claim for: Benjamin Sigel**  
Employee# [REDACTED]

**Appropriation: 429  
Agency Number: 150**

**TO WHOM IT MAY CONCERN:**

**The above employee of the University of Arkansas for Medical Sciences has been inadvertently underpaid due to an administrative error as follows:**

**“Employee is owed vacation payout that was owed from the prior fiscal year after transitioning below full-time status. \$16,154.40 is the amount of the prior fiscal year claim.”**

**Should additional information be required, please contact me at 296-1152.**

**Respectfully,**

**Michelle Thomisee  
Senior Director, Total Rewards and Shared Services**

**MLT/cmk**

**Encl.**

**August 7, 2023**

**Benjamin Sigel**

Employee# [REDACTED]

**“Employee is owed vacation payout that was owed from the prior fiscal year after transitioning below full-time status. \$16,154.40 is the amount of the prior fiscal year claim.”**

**TOTAL AMOUNT OF UNDERPAYMENT**

**\$16,154.40**

**LIST OF UAMS CLAIMS TO ARKANSAS CLAIMS COMMISSION**

<b><u>EMPLOYEE NAME</u></b>	<b><u>DEPARTMENT</u></b>	<b><u>CLAIM PAID</u></b>	<b><u>BALANCE</u></b>
Benjamin Sigel	COM PSY	-0-	\$16154.40
Total:			\$16154.40

cc: Cliff Ferren  
Controller's Office

**Note to Controller's Office**

**Under Act 176 of 1995, the payment, when authorized by the Commission, should be paid from regular salaries processed through normal payroll process.**

**MLT/cmk**


  
SELECT  
AGENCY


  
CLAIM  
INFORMATION


  
CLAIMANT  
INFORMATION


  
SUMMARY  
& REVIEW

## REVIEW

Please review the information you've provided below, make any needed changes and proceed to the final step. If you have questions about any part, use the CONTACT button above to see the contact options.

### STEP 1: AGENCY INFORMATION

University of Arkansas for Medical Sciences

### STEP 2: CLAIM INFORMATION

Claim Explanation.

If this involved a motor vehicle incident, please include a details of the accident (**location**, cars involved, police report number, etc.)

Term vacation payout that was due in prior fiscal year.

Incident Date

06/30/2019

Use MM/DD/YYYY format

Amount Sought (numbers only)

16154.40

If damages are unknown, enter 0

Tell us about the type of claim you're making:

- ☐ NO Does this claim involve damage to a motor vehicle?
- ☐ NO Does this claim involve damage to personal property?
- ☐ NO Does this claim involve personal injury?
- ☐ NO Are you seeking death benefits?
- ☐ NO Is this a breach of contract claim?
- ☐ NO Does this claim involve an unpaid bill?
- ☐ NO Are you seeking reissuance of a check or warrant?
- ☐ NO Are you seeking a disability benefits?
- ☐ NO Are you seeking a disability benefit scholarship?
- ☐ NO Are you seeking a reimburse of an expense?
- ☐ NO Do you want to file another type of claim?

### STEP 3: CLAIMANT INFORMATION

Who is filing this claim?

☒ Self ☐ Attorney on behalf of claimant ☐ Attorney on behalf of company or corporate entity

Claimant Information:

MR., MS., MR

Benjamin

Sigel




NO Is there a second claimant?

Your Promise:

**I CERTIFY THAT ALL INFORMATION CONTAINED IN THE ABOVE FORM IS ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE.**

NO

 PRINT THIS PAGE

 WAITING

# ARKANSAS STATE CLAIMS COMMISSION

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The undersigned certifies that to the best of my knowledge, information, and belief, this claim is not being presented for any improper purpose; this claim is warranted by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law or for establishing new law; and the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery.

Benjamin A Sigel  
Claimant Name (must be printed legibly)

B. Sigel  
Claimant Signature

## Acknowledgement

State of Arkansas

County of Pulaski

On this the 7th day of August, 2023, before me, the undersigned notary, personally appeared Benjamin A Sigel known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Theresa M Cheatham  
Signature of Notary Public

My Commission expires: 06/23/2025



[Seal of Office]

**BEFORE THE ARKANSAS STATE CLAIMS COMMISSION**

**BENJAMIN SIGEL**

**CLAIMANT**

**V.**

**CLAIM NO. 240157**

**UNIVERSITY OF ARKANSAS FOR  
MEDICAL SCIENCES**

**RESPONDENT**

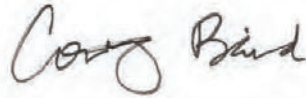
**ORDER**

This claim was filed by Benjamin Sigel against the University of Arkansas for Medical Sciences (the “Respondent”) for salary due in the amount of \$16,154.40.

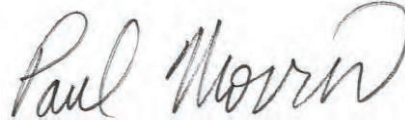
Respondent filed an answer on August 8, 2023, admitting liability in full.

The Arkansas State Claims Commission (the “Claims Commission”) unanimously allows this claim in the amount of \$16,154.40 and refers this claim to the General Assembly for review and placement on an appropriation bill pursuant to Ark. Code Ann. § 19-10-215(b).

IT IS SO ORDERED.



ARKANSAS STATE CLAIMS COMMISSION  
Courtney Baird



ARKANSAS STATE CLAIMS COMMISSION  
Paul Morris, Chair



ARKANSAS STATE CLAIMS COMMISSION  
Sylvester Smith

DATE: September 22, 2023

**Notice(s) which may apply to your claim**

- (1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).
- (2) If a Claimant is awarded less than \$15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.
- (3) Awards or negotiated settlement agreements of \$15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).