New York City Comptroller
John C. Liu

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Form Version: NYC-COMPT-BLA-PI1-A

Personal Injury Claim Form

Electronically filed claims must be filed at the NYC Comptroller's Website. If your claim is not resolved within 1 year and 90 days from the date of occurrence you must start legal action to preserve your rights.

I am filing:

- ◯ On behalf of myself.
- ◯ On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	
First Name:	
Relationship to the claimant:	

Claimant Information

*Last Name:	
*First Name:	
Address:	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	
Country:	USA
Date of Birth:	*Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
*Email Address:	
Retype email Address:	
Occupation:	

City Employee? ◯ Yes ◯ No ◯ NA

Gender ◯ Male ◯ Female ◯ Other

◯ Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:	
Firm or First Name:	
Address:	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	
Tax ID:	
Phone #:	
*Email Address:	
Retype email Address:	

**** Denotes required fields. The email of the Claimant or Attorney is required.***

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The time and place where the claim arose

*Date of Incident: *Format: MM/DD/YYYY*

Time of Incident: *Format: HH:MM AM/PM*

*Location of Incident:

Address:

Address 2:

City:

State: NEW YORK

Borough:

***Manner in which claim arose:**

Medical Information

1st Treatment Date: *Format: MM/DD/YYYY*

Hospital/Name:

Address:

Address 2:

City:

State: NEW YORK

Zip Code:

Date Treated in Emergency Room: *Format: MM/DD/YYYY*

Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

Employment Information (If claiming lost wages)

Employer's Name:

Address

Address 2:

City:

State: NEW YORK

Zip Code:

Work Days Lost:

Amount Earned Weekly:

Treating Physician Information

Last Name:

First Name:

Address:

Address 2:

City:

State: NEW YORK

Zip Code:

The items of damage or injuries claimed are (include dollar amounts):

**** Denotes required field(s).***

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Witness 1 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Witness 2 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Witness 3 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Witness 4 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Witness 5 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Witness 6 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

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Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Non-City vehicle driver

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	

Insurance Information

Insurance Company Name:	
Address	
Address 2:	
City:	
State:	NEW YORK
Zip Code:	
Policy #:	
Phone #:	

Non-City vehicle information

Make, Model, Year of Vehicle:	
Plate #:	
VIN #:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	

Description of claimant:

- ◯ Driver
- ◯ Passenger
- ◯ Pedestrian
- ◯ Bicyclist
- ◯ Motorcyclist
- ◯ Other

Total Amount Claimed: *Format: Do not include "$" or ",".*

*The **Total Amount Claimed** can only be entered once the following required fields are entered:*

Claimant Last Name
Claimant First Name
Claimant Email or Attorney Email
Date of Incident
Location of Incident
Manner in which claim arose

I certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to criminal penalties and civil liabilities.