

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.

 \bigcirc On behalf of someone else. If on someone else's behalf, please provide the following information.

\bigcirc	Attorney	is	fi	lina
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Last Name:			Attorney Informat	ion (If claimant is represented by attorney)
First Name:			Firm or Last Name:	
Relationship to			Firm or First Name:	
the claimant:			Address:	
			Address 2:	
Claimant Infor	mation		City:	
*Last Name:			State:	NEW YORK
*First Name:			Zip Code:	
Address:			Tax ID:	
Address 2:			Phone #:	
City:			*Email Address:	
State:	NEW YORK		Retype email	
Zip Code:			Address:	
Country:	USA			
Date of Birth:	F	ormat: MM/DD/YYYY		
Soc. Sec. #				
HICN: (Medicare #)				
Date of Death:	F	ormat: MM/DD/YYYY		
Phone:				
*Email Address:				
Retype email Address:				
Occupation:				
City Employee?	Yes O	No ONA		
Gender	∩ Male (Female Other		



New York City Comptroller John C. Liu

The time and place where the claim arose

Format: MM/DD/YYYY	1st Treatment Date:	Format: MM/DD/YYYY
Format: HH:MM AM/PM	Hospital/Name:	
	Address:	
	Address 2:	
	City:	
	State:	NEW YORK
	Zip Code:	
	Date Treated in	Format: MM/DD/YYYY
	Emergency Room:	
	Was claimant taken an ambulance?	to hospital by OYes ONO ONA
NFW YORK	Employment Infor	mation (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:	
	Format: HH:MM AM/PM	Format: HH:MM AM/PM Hospital/Name: Address: Address: Address: Address: Address: Address: Address: Date Treated in Emergency Room: Was claimant taken an ambulance? NEW YORK Employment Infor Employer's Name: Address Address 2: City: State: Zip Code: VORK Employer's Name: Address Address Address Address Address Address Address Address City: State: Zip Code: Work Days Lost: Amount Earned Weekly: Treating Physician Last Name: Address: Address: Address: Address: Address: Address 2: City: State: Zip Code: Zip Code:

Medical Information



New York City Comptroller John C. Liu

Witness 1 Information

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

Witness 4 Information

NEW YORK

Witness 5 Information

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

Witness 3 Information

Witness 2 Information

Last Name: First Name: Address Address 2:

City: State:

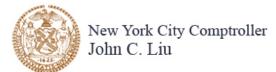
Zip Code:

Last Name:		
First Name:		
Address		
Address 2:		
City:		
State:	NEW YO	DRK
Zip Code:		

NEW YORK

Witness 6 Information

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



Complete if claim involves a NYC vehicle

Owner of vehicle c	laimant was traveling in	Non-City vehicle driver
Last Name:		Last Name:
First Name:		First Name:
Address		Address
Address 2:		Address 2:
City:		City:
State:	NEW YORK	State: NEW YORK
Zip Code:		Zip Code:
Insurance Informa	tion	Non-City vehicle information
Insurance Company Name:		Make, Model, Year of Vehicle:
Address		Plate #:
Address 2:		VIN #:
City:		City vehicle information
State:	NEW YORK	
Zip Code:		Plate #:
Policy #:		
Phone #:		City Driver Last Name:
Description of claimant:	O Driver O Passenger	City Driver First
	○ Pedestrian ○ Bicyclist	Name:
	○ Motorcyclist ○ Other	

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.