New York City Comptroller
Scott M. Stringer

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

Form Version: NYC-COMPT-BLA-PD1-C

Property Damage or Loss 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:	
Zip Code:	
Tax ID:	
Phone #:	
*Email Address:	
*Retype Email Address:	

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:	

Property Clerk Voucher Number:	
District Attorney Release Number:	

**** Denotes required fields.***
A Claimant OR an Attorney Email Address is required.

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***Manner in which claim arose:**

**** Denotes required field.***

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

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Witness 1 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 2 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 3 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 4 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 5 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Witness 6 Information

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	Phone #:

Police Information

Police Officer Last Name:	
Police Officer First Name:	
Shield Number:	
Precinct:	
Report Number:	

Please indicate which of the following reports you have

- ☐ Accident Report
- ☐ Aided Report
- ☐ Complaint Report

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Insurance Information

Do you have insurance?	◯ Yes	◯ No
Did you report your accident to your insurance company?	◯ Yes	◯ No
Were you paid by your insurance company?	◯ Yes	◯ No
Is payment pending?	◯ Yes	◯ No

Deductible Amount:	
Insurance Company Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Policy #:	
Phone #:	
Agent Name:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	
Total Amount Claimed:	

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

Format: Do not include "$" or ",".

Claimant Last Name
Claimant First Name
Claimant Address, City, State, Zip code, Country
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.