

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

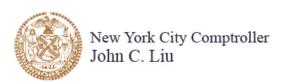
Form Version: NYC-COMPT-BLA-PI1-B

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.	Attorney is filing.		
On behalf of someone else. If on someone else's behalf, please provide the following information.	Attorney Information (I	f claimant is represented by attorney)	
Last Name:	Firm or Last Name:		
	Firm or First Name:		
First Name:	Address:		
Relationship to the claimant:	Address 2:		
	City:		
Claimant Information	State:		
	Zip Code:		
*Last Name:	Tax ID:		
*First Name:	Phone #:		
Address:	*Email Address:		
Address 2:	*Retype Email		
City:	Address:		
State:	The time and place whe	re the claim arose	
Zip Code:	*Date of Incident:	Format: MM/DD/YYYY	
Country:	Time of Incident:	Format: HH:MM AM/PM	
Date of Birth: Format: MM/DD/YYYY	*Location of		
Soc. Sec. #	Incident:		
HICN: (Medicare #)			
Date of Death: Format: MM/DD/YYYY			
Phone:			
*Email Address:			
*Retype Email Address:			
Occupation:			
City Employee?			
Gender			
	Address:		
	Address 2:		
	City:		
	State:		
	Borough:		

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



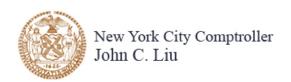
*Manner in which claim arose:	
* Denotes required :	field.



ALLANDA	
The items of	
damage or injuries	
damage or injuries claimed are	
include dollar	
amounts):	
inounts).	



Medical information		witness i information		
1st Treatment Date:	Format: MM/DD/YYYY	Last Name:		
Hospital/Name:	,	First Name:		
Address:		Address		
Address 2:		Address 2:		
City:		City:		
State:		State:		
Zip Code:		 Zip Code:		
Date Treated in Emergency Room:	Format: MM/DD/YYYY	Witness 2 Information		
Was claimant taken to hospital by Yes No NA an ambulance?		Last Name:		
		First Name:		
Employment Information	n (If claiming lost wages)	Address		
Employer's Name:		Address 2:		
Address		City:		
Address 2:		State:		
City:		Zip Code:		
State:		Witness 3 Informa	ition	
Zip Code:		Last Name:		
Work Days Lost:		First Name:		
Amount Earned		Address		
Weekly:		Address 2:		
Treating Physician Information		City:		
Last Name:		State:		
First Name:		Zip Code:		
Address:				
Address 2:		Witness 4 Informa	tion	
City:		Last Name:		
State:		First Name:		
Zip Code:		Address		
		Address 2:		
		City:		
		State:		
		Zip Code:		



Complete if claim involves a NYC vehicle

Owner of vehicle cl	aimant was trave	ling in	Non-City vehicle dri	iver	
Last Name:			Last Name:		
First Name:			First Name:		
Address			Address		
Address 2:			Address 2:		
City:			City:		
State:			State:		
Zip Code:			Zip Code:		
Insurance Informat	ion		Non-City vehicle inf	ormation	
Insurance Company Name:			Make, Model, Year of Vehicle:		
Address			Plate #:		
Address 2:			VIN #:		
City:			City vehicle informa	City vehicle information	
State:			Plate #:		
Zip Code:			- 1 iate π.		
Policy #:					
Phone #:			City Driver Last Name:		
Description of claimant:	Oriver	Passenger	City Driver First		
	Pedestrian	Bicyclist	Name:		
	Motorcyclist	Other			
Total Amount Claimed:			Format: Do not include "\$" or ",".		
The Total Amount C	laimed can only be	antarad anca the falla	wina		

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