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-PD1-M

Property Damage or Loss Claim Form

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office, 1 Centre Street, Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 year and 90 days of the occurrence,* you must start legal action to preserve your rights.
TYPE OR PRINT

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:	
Zip Code:	
Country:	
Date of Birth:	*Format: MM/DD/YYYY*
Soc. Sec. #	
HICN: (Medicare #)	
Date of Death:	*Format: MM/DD/YYYY*
Phone:	
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:	

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

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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*

Property Clerk Voucher Number:

District Attorney Release Number:

*Location of Incident:

Address:

Address 2:

City:

State:

Borough:

***Manner in which claim arose:**

Attach extra sheet(s) if more room is needed.

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

Attach extra sheet(s) if more room is needed.

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

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Witness 1 Information

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

Witness 2 Information

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

Witness 3 Information

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

Witness 4 Information

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

Witness 5 Information

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

Witness 6 Information

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

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:**	

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

_____ _____

Date Signature of Claimant

State of New York
County of

I, _____, being duly sworn depose and say that I have read the foregoing NOTICE OF CLAIM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters. I believe them to be true.

Sworn before me this day_____

Signature of Claimant_____ Signature of notary_____

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