

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

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

Personal Injury Claim Form

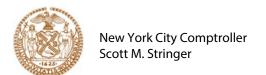
Electronically filed claims must be filed at the NYC Comptroller's Website. If your claim is not resolved within 1 year and 90 days from the date of occurrence you must start legal action to preserve your rights.

I am filing: ○ On behalf of myself.	Attorney is filing.	
On behalf of someone else. If on someone else's		f claimant is represented by attorney)
behalf, please provide the following information	n. Firm or Last Name:	
Last Name:	Firm or First Name:	
First Name:	Address:	
Relationship to the claimant:	Address 2:	
the Claimant.	City:	
	State:	
Claimant Information	Zip Code:	
*Last Name:	Tax ID:	
*First Name:	Phone #:	
*Address:	*Email Address:	
Address 2:	*Retype Email	
*City:	Address:	
*State:	The time and place whe	ere the claim arose
*Zip Code:	*Date of Incident:	Format: MM/DD/YYYY
*Country:	<u> </u>	Format: HH:MM AM/PM
Date of Birth: Format: MM/DD/YYYY	Time of Incident: *Location of	TOTTIAL. TIT I.WINI AWI/FW
Soc. Sec. #	Incident:	
HICN: (Medicare #)		
Date of Death: Format: MM/DD/YYYY		
Phone:		
*Email Address:		
*Retype Email Address:		
Occupation:		
City Employee? Yes No NA		
Gender		
	Address:	
	Address 2:	
	City:	
	*State:	
	Borough:	

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



411(13)	
*Manner in which	
ala tana ana ana	
claim arose:	



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



Medical Information		Witness 1 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:	Phone:	
Date Treated in Emergency Room:	Format: MM/DD/YYYY	Witness 2 Information		
Was claimant taken to hos an ambulance?	pital by Yes No NA	Last Name:		
		First Name:		
Employment Informatio	n (If claiming lost wages)	Address		
Employer's Name:		Address 2:		
Address		City:		
Address 2:		State:		
City:		Zip Code:	Phone:	
State:		Witness 3 Informati	on	
Zip Code:		Last Name:		
Work Days Lost:		First Name:		
Amount Earned Weekly:		Address		
Treating Physician Information		Address 2:		
Last Name:		City:		
First Name:		State:		
Address:		Zip Code:	Phone:	
Address 2:		Witness 4 Informati	on	
City:		Last Name:		
State:		First Name:		
Zip Code:		Address		
	_	Address 2:		
		City:		
		State:		
		Zip Code:	Phone:	



Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in		Non-City vehicle di	Non-City vehicle driver		
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 in	formation	
Insurance Company Name:			Make, Model, Year of Vehicle:		
Address			Plate #:		
Address 2:			VIN #:		
City:			City vehicle information		
State:			Plate #:		
Zip Code:			Plate #:		
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		e entered once the follow	wing		

Claimant Last Name
Claimant First Name
Claimant Address, City, State, Zip Code, and Country
Claimant Email or Attorney Email
Date of Incident
Location of Incident (including State)
Manner in which claim arose