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-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.

◯ 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: | |

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

New York City Comptroller
Scott M. Stringer

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

***Manner in which claim arose:**

**** Denotes required field.***

New York City Comptroller
Scott M. Stringer

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

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

New York City Comptroller
Scott M. Stringer

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

**Medical Information**

1st Treatment Date: *Format: MM/DD/YYYY*
Hospital/Name:
Address:
Address 2:
City:
State:
Zip Code:
Date Treated in Emergency Room: *Format: MM/DD/YYYY*
Was claimant taken to hospital by an ambulance? ◯ Yes ◯ No ◯ NA

**Employment Information (If claiming lost wages)**

Employer's Name:
Address
Address 2:
City:
State:
Zip Code:
Work Days Lost:
Amount Earned Weekly:

**Treating Physician Information**

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

**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:

New York City Comptroller
Scott M. Stringer

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

**Complete if claim involves a NYC vehicle**

**Owner of vehicle claimant was traveling in**

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

**Non-City vehicle driver**

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

**Insurance Information**

| | |
|---|---|
| Insurance Company Name: | |
| Address | |
| Address 2: | |
| City: | |
| State: | |
| Zip Code: | |
| Policy #: | |
| Phone #: | |

**Non-City vehicle information**

| | |
|---|---|
| Make, Model, Year of Vehicle: | |
| Plate #: | |
| VIN #: | |

**City vehicle information**

| | |
|---|---|
| Plate #: | |
| City Driver Last Name: | |
| City Driver First Name: | |

**Description of claimant:**

- ◯ Driver
- ◯ Passenger
- ◯ Pedestrian
- ◯ Bicyclist
- ◯ Motorcyclist
- ◯ Other

---

**Total Amount Claimed:** *Format: Do not include "$" or ",".*

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

*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*

*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.*