



# 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:

\*Zip Code:

\*Country:

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:

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:**

A large, empty rectangular box intended for the user to provide details on the manner in which the claim arose.

**\* Denotes required field.**



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

A large, empty rectangular box intended for the user to provide details of damage or injuries claimed, including dollar amounts.



**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  Yes  No  NA  
an ambulance?

**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:



**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.*